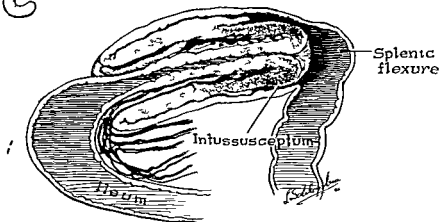
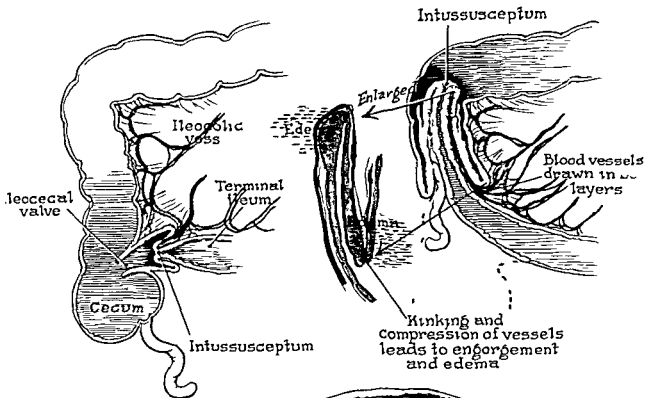


INTUSSUSCEPTION IN INFANTS AND CHILDREN

Frontispiece — The pathological changes in the acute form of invagination are chiefly of two kinds 1 Obstruction of the bowel 2 Strangulation of the intussusceptum The obstruction is due not only to the narrowing of the lumen of the bowel by the invagination but also to the swelling of the invaginated portion caused by the constriction of the blood vessels supplying the intussusception at the neck of the intussusciptiens The acuity of the symptoms is always proportionate to the severity of the strangulation at this point The circular constriction interferes with the return of venous blood from the intussusceptum which is followed by edema complete stasis and gangrene of the constricted portion An acute invagination becomes irreducible by ordinary means within a few hours on account of the appearance of edema in the intussusceptum If the strangulation is less intense the passive congestion precedes a plastic inflammation of the serous surfaces held in apposition and adhesions form which again oppose or render a reduction impossible Nicholas Senn 1897

The vast majority of intussusceptions in infants and children are of the kind shown here The intussusception begins at or near the ileo cecal valve and there is no obvious local anatomical lesion to cause it From the first moment there is simultaneous interference with the patency of the alimentary canal and with the vascular supply of the intussusceptum The drawings indicate the manner in which the mesenteric vessels are drawn between the layers of the intussusception and compressed The slight interference with lymphatic and venous drainage which occurs almost at once results in edema and an increase in the tissue pressure This further increases the resistance to the return of venous blood Venules and capillaries become enormously engorged Edema increases until there is complete obstruction to venous outflow As arterial blood continues to pump in the tissue pressure rises until it is higher than arterial pressure and gangrene ensues The drawings indicate the sharp U shaped turns of the bowel and of the mesenteric vessels at either end of the intussusceptum The outer coat of the intussusceptum is isolated between these two sharp bends and is understandably the first to become gangrenous Gangrene makes its appearance in this coat near the tip of the intussusceptum and progresses backward towards the neck of the intussusception Identical changes follow in the innermost layer of the intussusceptum The intussusciptiens is rarely damaged



PEDIATRIC SURGICAL MONOGRAPH SERIES

Edited by

MARK M RAVITCH M D

Associate Professor of Surgery

The Johns Hopkins University School of Medicine

Surgeon in Chief The Baltimore City Hospitals

Baltimore Maryland

INTUSSUSCEPTION

IN INFANTS

AND CHILDREN

By

MARK M RAVITCH, M D

Associate Professor of Surgery The Johns Hopkins University School of Medicine

Surgeon in Chief The Baltimore City Hospitals

Baltimore Maryland



CHARLES C THOMAS • PUBLISHER
Springfield Illinois U S A

CHARLES C THOMAS PUBLISHER
BANNERSTONE HOUSE
301 327 East Lawrence Avenue Springfield Illinois U.S.A

Published simultaneously in the British Commonwealth of Nations by
BLACKWELL SCIENTIFIC PUBLICATIONS LTD OXFORD ENGLAND

Published simultaneously in Canada by
THE RYERSON PRESS TORONTO

his book is protected by copyright No
part of it may be reproduced in any manner
without written permission from the publisher

9 by CHARLES C THOMAS PUBLISHER

Library of Congress Catalog Card Number 59 6747

With THOMAS BOOKS careful attention is given to all details of
manufacturing and design It is the Publisher's desire to present books
that are satisfactory as to their physical qualities and artistic possibilities
and appropriate for their particular use THOMAS BOOKS will be true
to those laws of quality that assure a good name and good will

To

DOCTOR EDWARDS A PARK

*This book is humbly dedicated by one of the many men and women
in medicine whose lives and careers he so profoundly influenced*

PREFACE

The field of pediatric surgery has expanded so rapidly in recent years that there would appear to be a place for a series of monographs devoted to its various phases. The body of information available is now much greater than can be satisfactorily handled in the limited space afforded in a textbook. Some of these monographs will deal with single conditions or diseases others of wider scope with organ systems or specialty fields within pediatric surgery.

Only a very few years ago in the limited field which was then pediatric surgery intussusception occupied a prominent place. It therefore seems eminently suitable that the first monograph in the series should deal with this subject of traditional interest in pediatric surgery.

In 1933 Dr Dean D Lewis then Professor of Surgery at the Johns Hopkins University School of Medicine returned from a meeting of the American Surgical Association at which Dr E H Miller of Chicago had presented a paper on Intussusception. Dr Miller had described his own results which he considered poor and referred to the remarkable results of Hipsley in Australia with reduction of intussusception by hydrostatic pressure. Dr Lewis at a student clinic in customary fashion read to us directly from the writings of those concerned with the problem under discussion—in this instance the classical work of Clubbe—the great Australian student of intussusception. I was a third year student at the time and interested in pediatric problems. Reading of the work with hydrostatic

pressure reduction of Clubbe and of Hipsley then of Hirschsprung and his successors in Scandinavia I became enthusiastic about it and to try the method. These attempts began in 1939 when I was a junior Assistant Resident. That I was permitted to make these attempts was due to the support and encouragement of Dr E A Pratt then directing the Harriet Lane Home for Invalid Children and Dr Warfield M Firor directing the Department of Surgery. Since 1941 these studies have profited from the warm interest of Dr Alfred Blalock Professor of Surgery and Director of the Department of Surgery.

In a hospital where from its inception the ward services have been almost wholly in the control of the Resident Staff I owed much to the Pediatric House Staff who were enthusiastic from the first and to my various predecessors in the surgical residency who varied from tolerant to warm cooperation but were always helpful—Doctors E S Stafford David H Sprong Jr August F Jonas Jr James M Mason III and William G Watson.

In recent years the surgical house staff has continued the program more or less independently and it is a pleasure to report that the clinical results have steadily improved.

Dr Robert M McCune Jr while still a cal student contributed heavily to the laboratory experiments and clinical analyses upon which I have drawn freely.

Intussusception as a disease has fascinated pediatricians surgeons and pathologists in the p

those whose connection with the subject is noteworthy are John Hunter D Arcy Rokitansky Nothnagel Nicholas Senn and Hutchinson Hirschsprung and Sir Clubbe

but attempting to write a monograph so as to repel the more general reader, we had to treat in systematic fashion the histology and the clinical features of the disease and its therapy. Because of our special interest in the hydrostatic pressure reduction of intussusception under fluoroscopic control we included a substantial series of reproduc-

tions of films taken during such reductions. It has been our observation that few pediatricians or surgeons who have had experience of the method in operation in seasoned hands have failed to be convinced of its value. The numerous roentgenographic films reproduced which constitute a series of illustrated case histories will it is hoped serve as a body of clinical experience for those unacquainted with this method and as an atlas for reference to illustrate the various appearances of intussusception during the barium enema treatment.

M M R

TABLE OF CONTENTS

CHAPTER I pp 3 11

MATTERS OF HISTORICAL INTEREST CONCERNING INTUSSUSCEPTION

First descriptions p 3 treatment pp 4 5 6 7 (non-operative pp 4 5 Operative pp 6 7) radiographic diagnosis pp 8 9 10 barium enema reduction p 10

CHAPTER II pp 11 27

THE CLINICAL PICTURE OF INTUSSUSCEPTION

Incidence p 13 sex p 14 race p 14 age p 14 seasonal incidence p 15 birth rank p 16 nutrition and previous health p 16 Previous attacks spontaneous reduction p 17 Spontaneous sloughing p 18 Symptoms p 19 pain p 19 blood p 20 constipation p 20 diarrhoea p 20 Examination p 20 fever p 20 white blood cell count p 21 prostration p 21 dehydration p 21 associated diseases p 22 abdominal resistance p 22 mass p 22 peristalsis p 22 prolapse p 22 Duration p 23 Occurrence of specific lesions causing intussusception pp 23 24 25 26

CHAPTER III pp 28-40

ERRORS IN THE DIAGNOSIS OF INTUSSUSCEPTION

Inexcusable errors p 30 errors because of prolonged duration pp 30 31 because of pre existing severe illness pp 32 33 34 35 because of suspected dysentery pp 35 36 37 38

CHAPTER IV pp 41 53

PATHOLOGICAL AND EXPERIMENTAL STUDIES IN INTUSSUSCEPTION

Reported observations pp 41 42 experimental technique pp 42 43 44 45 46 bacteriological studies pp 47 48 49 histologic studies pp 48 49 50 51 52

CHAPTER V pp 54 117

TREATMENT OF INTUSSUSCEPTION

A Operative pp 54 to 66 Simple reduction pp 54 55 resection methods pp 56 to 62 operative results pp 62 to 66 postoperative therapy p 66
B Non-operative pp 66 to 117 Development of the method pp 66 67 68 technique pp 69 to 79 criteria of reduction pp 80 81 82 83 84 85 Results pp 85 to 117 Johns Hopkins series pp 85 113 recurrence pp 85 86 confirmatory operation p 87 operative completion of reduction pp 100-109 subsequent mechanical intestinal obstruction p 107 enema reduction at operation pp 110 111 indications p 111 collected results pp 112 113 114 objections pp 115 116

INTUSSUSCEPTION IN INFANTS AND CHILDREN

MATTERS OF HISTORICAL INTEREST CONCERNING INTUSSUSCEPTION

Accustomed as we are to considering intussusception as a common disease of infancy with an easily recognized striking and pathognomonic clinical picture it comes as something of a surprise to realize that intussusception has been known and recognized probably no more than three hundred years. Otto Leichtenstern who wrote extensively on intussusception in the 1870's is authority for the statement that J. C. Peyer in 1677 first clearly recorded the clinical differentiation between volvulus and intussusception. Barbette a few years earlier clearly described intestinal invagination.

Discussions of the historical aspects of intussusception regularly state with confidence that Hippocrates advised the use of enemata and the bellows injection of air for intussusception and that Praxagoras of Cos even advised operation for the same disease. A close reading of the pertinent sections of Hippocrates which are to be found in the Littré translation show that he was talking simply of ileus and that there is no suggestion or indication that he was speaking of intussusception or knew it as a specific form of ileus. He did it is quite true talk of the use of enemas for ileus although they seemed to be oil injection enemas and not enemas of large volume. He did specifically state that if these failed a bellows should be connected to the anus and the bowel inflated with air. The only information we have on Praxagoras is that which has come down to us from the lost Greek writings of

Soranus of Ephesus by way of the translation into Latin of Caelius Aurelianus. Here there is a very long section on Acute Intestinal Obstruction which the Greeks call Ileus. He states that the various terms for intestinal obstruction were given because the patient has a feeling that the folds of his intestine are tied up and twisted or because the pneuma is blocked and shut off the resulting involution of the flow producing cramps and twisting pains or else because the violent pains over the parts affected cause the patient to be bent over twisted and doubled up. He goes on to discuss other designations and their etiology with their origin and meaning such as fence obstruction etc. nowhere is there a suggestion of invagination or involution. The symptoms described are the symptoms of mechanical intestinal obstruction but any mention of a bloody discharge from the rectum is conspicuously absent and there is no mention of any specific type of ileus peculiar to children or infants.

In the Eighteenth Century Intussusception was well recognized and John Hunter's paper in 1789 described the specimen from a fatal intussusception in a nine month old child. He read his paper before a small group that met monthly at Slaughter's Coffee House in St. Martin's Lane and called themselves A Society for the Improvement of Medical and Chirurgical Knowledge. This was a select society of twelve members selected from the staff of St. Bartholomew's, St. George's, Guy's and St. Thomas's. Hunter's ana-

ical observations were accurate but his therapeutic suggestions leave something to be desired everything that can increase the action of the sinues downwards is to be particularly ded I should therefore advise giving vomits as a view to invert the peristaltic motion of the running gut which will have a tendency to ing the intestines into their natural situation Although intussusception was well known in Eighteenth Century it is astonishing that a en of a considerable number of textbooks of ery and textbooks of the diseases of children is until the second half of the Nineteenth ury almost no mention of intussusception ntussusception in the mid Nineteenth Cen was recognized as a nearly universally fatal ise Leichtenstern pointed out that the mor ty in reported cases was 88% in the first six nths of life 82% in the next six months of life 72% from two to ten years perative therapy was rarely undertaken sters of various types were employed but it

would appear that most physicians did not cre- fully and consciously employ these in an effort to reduce the intussusception by hydrostatic pres- sure It is equally obvious that others did attempt just that knowingly Air was also frequently in- jected into the rectum either by a bellows or gas from a generator of one kind or another The use of a wind to repose the intestines then a standard practice as it had been for some centu- ries past was as ineffective as it might be expected to be More attention seems to have been paid to the construction of the wind and the character of its tip than to the hopelessness of its use A common preference in the Nineteenth Century seemed to be a whalebone bougie with a soft covering

The following letter to the Editor of the *Lan- cet* which appeared in the issue of March 18th 1838 under the title Intussusception in Chil- dren gives some idea of the therapeutic argu- ments at the time

Sir

The subject of intussusception having lately been discussed at the two prin- cipal medical societies in London and nothing new having been elicited on these discussions I take the liberty of suggesting to the profession through the medium of your valuable periodical the trial of inflating the bowels by means of a Clyster pipe attached to a common pair of bellows It has fallen to my lot to witness several of these distressing cases in children The nature of the obstruction was foretold during life and unfortunately verified by postmortem examination The last case of the kind which came under my care about two years since presented all the usual symptoms intolerable restlessness the most obstinate sickness the singularly distressed state of countenance and shrunken features The usual reme- dies we had recourse to viz warm baths glysters anodyne frictions over the abdo- men &c but without avail As a forlorn hope I made trial of inflation by the above means with a most happy result The sickness immediately ceased the child within an hour passed a natural stool fell into a sleep and in the morning was almost without ailment

I am Sir your constant reader and obedient servant

Samuel Mitchell Surgeon
Kingston on Thames
February 26 1838

A quotation from J. Lewis Smith's *A Treatise on the Diseases of Infancy and Childhood* will give a picture of the disease in 1872 just before the reports of Hutchinson and Hirschsprung.

Prognosis—Intussusception is in its nature so grave an accident that the physician called to a case should always expect to predict a fatal result.

Cathartic remedies act as a vis a tergo and may cause a still further descent of the inverted intestine. Quicksilver was similarly condemned. He then went on to state: "The proper treatment consists in attempts to reduce the peristalsis by pressure from below and is applied either by liquid injections into the rectum or which is far more preferable inflation of the lower intestine by air or gas. If reduction is not effected after sufficient trial the indication is to maintain the strength of the patient and give palliative remedies in the hope that recovery may take place through the process of sloughing and adhesive inflammation."

An apparatus for the production and injection of carbonic acid gas has been invented by Schultz and Warner of this city (New York) and is manufactured by them. It consists essentially of two glass chambers, one over the other. In the lower one a bicarbonate is placed and in the upper an acid in a liquid state. By the gradual admixture of the two carbonic acid is set free. An elastic tube conveys the gas from the lower chamber. This apparatus has been used by physicians of this city for the reduction of intussusception and other purposes and is a useful invention.

The same firm and several others in this city prepare for the shops quart bottles of highly charged carbonic acid water from which when inverted a powerful current of carbonic acid gas can be obtained. Two or three of these bottles with a portion of the tube from Davidson's syringe which can be readily attached to the stem from which the gas escapes constitute all that is required for an ordinary case.

Whether air or carbonic acid is employed it is necessary to produce distention of the intestine to its fullest extent below the seat of the complaint without endangering rupture and of

course the sooner it is out the better the chance of success.

The employment of quicksilver by the rectum with the thighs elevated has been suggested to me as a dernier resort.

As for operation— I apprehend that there are few surgeons at the present day who would perform or recommend this mode of treatment in a child.

In the first edition of the famous *Text On the Diseases of Infancy and Childhood* by L. Emmett Holt the treatment of intussusception which is advised is insufflation with the bellows and simultaneous manipulation through the abdomen. If one preferred it was acceptable to employ an enema holding the reservoir four to five feet above the patient and raising it if necessary to six to eight feet operation to be performed if these failed. In 225 collected cases in children with the use of air or fluid Holt pointed out there had been only one rupture of the intestine.

Nicholas Senn the brilliant and many famed surgeon of Chicago who had studied intussusception experimentally felt that gas was infinitely preferable to fluid. His are the first experiments evaluating pressure reduction. He employed hydrogen gas either manufactured elsewhere or manufactured on the spot in a generator with zinc chips and sulphuric acid and stored in a large rubber balloon. In experiments in which intussusceptions were produced in animals and the animals then operated upon 36 hours later he states: "the bowel at the point of operation was very vascular and the neck of the intussusciens covered with plastic exudation. The sutures (previously inserted to prevent spontaneous reduction) were removed and the rectum distended with gas for the purpose of effecting reduction. As soon as the colon had become thoroughly distended the adhesions which had formed gave way with an audible noise and complete reduction followed in such a manner that the point last invaginated was first released. As the force necessary to rupture the adhesions and reduce the bowel produced no

ity of any kind to the intestine below or at seat of invagination this experiment would d to prove that insufflation can be practiced successfully in cases of invagination of several days duration. The pressure upon the rubber balloon should be uninterrupted and almost exceed two pounds to the square inch. Invagination is effected by inflation by two great forces. In the first place the steady pressure of the gas distends the bowel and the sheath and the returning cylinder which makes traction upon the neck of the intussusciens while the column of gas by its pressure against the apex of the intussusceptum is a direct reduction force.

Reduction was resisted after a time either the swollen edematous intussusceptum or by constrictions of the neck of the intussusciens or between the serous surfaces throughout the invaginated portion of the bowel. From these observations I have come to the conclusion that reduction by gentle but efficient distention of the bowel below the invagination would succeed in the majority of cases if this procedure practiced before either of the two principal conditions which cause irreducibility have had time to make their appearance.

At this time however the feasibility of operation upon infants with intussusception had not been established.

Barbette a surgeon of Amsterdam wrote in the middle of the Seventeenth Century suggested that rather than allow patients with intussusception to die it might be preferable to cut through the abdominal muscles and draw the invaginated intestines apart with the fingers. Nuck's case was reported by Haller in 1714. The patient was a woman of 50 who recovered.

The second patient known to have been operated upon for intussusception was an adult who was operated upon by Professor Olile of Dresden and reported in 1817 by J. A. Fiedler. His patient died.

The third case and the second successful one was that operated upon by Fuchsius and report-

ed in Hufeland's Journal February 1825. This was a man of 28. Fuchsius not only operated successfully but opened the bowel to aid in the resection and sutured it so skilfully that no fecal fistula developed.

The first certain laparotomy for intussusception in a child was by Gerson and was reported by Hachmann of Hamburg in 1810. This was a 12 week old infant. A good portion of the intussusception was reduced before gangrenous bowel suddenly delivered and tore with a fatal outcome.

The next recorded operation for intussusception was successful, and was the first one in the United States. It was an operation performed by Doctor John R. Wilson of Tennessee and was reported by his pupil Mr W. W. Thompson to the *Pennsylvania Journal of Medicine and the Associated Sciences*, 1835, Volume 18, page 362. The paper is titled "A Case of Intussusception in which an Operation was Successfully Resorted to by John R. W. Wilson M. D. of Rutherford County Tennessee in December 1831." The patient was a negro slave who had failed to respond to the customary treatment of active purgation and metallic mercury by mouth. The reduction was easily effected at operation and the author concluded his recovery was rapid and entire. The success of this case in which the operation was so long deferred and at last performed under such unfavorable circumstances warrants the propriety of resorting to it in the disease and proves that relief may occasionally be afforded by this means when all others have failed.

Wilson's grandson O. H. Wilson Professor Emeritus of Pediatrics at Vanderbilt University School of Medicine reports the finding of Doctor John R. Wilson's day book with an entry for November 20, 1831—\$5.00 for operation of Castration on Chris Dements, a boy with a record of several subsequent visits. A homelike enough memorandum of an historic operation.

There were a few other reported cases of operations for intussusceptions in adults and in infants among them unsuccessful operations in

England by Spencer Wells the renowned ovarietomist one of the founders of Gynecology and in Russia by Pirogoff the great military surgeon On November 11 1873 Jona than Hutchinson read before the Royal Medical and Chirurgical Society his first paper on Intussusception reporting a successful operation performed in 1871 on a two year old infant referred to him by Warren Tay He stated—

Our first measure of treatment consisted in putting the child under chloroform and then whilst she was held up by the feet distending the rectum to the utmost with warm water

By this means the involted part could be forced up into the abdomen so as to be quite out of reach of the finger and once or twice I tried to hope the reduction had been effected On each occasion however when the lower bowel was allowed to empty itself the intussuscepted part became prolapsed as before and showed clearly that we had gained nothing

It was very evident from the child's condition that unless relief were afforded she would not live long and I therefore felt justified in telling the parents that although an operation would become in itself very dangerous yet I felt that it afforded the only chance

He made a lower midline incision withdrew the six inch long intussuscepted mass reduced the intussusception without any difficulty and replaced the bowel The operation had been an extremely simple one and had not occupied more than two to three minutes

From this time on although it is obvious intussusception was still an extremely grave disease and carrying in spite of all a high mortality it was considered a disease in which the outcome could be materially affected for the better by proper treatment Theretofore recovery following rectal injection had been irregular and uncertain and operation had rarely been attempted Such survivals as did occur were due in the main either to spontaneous reduction of the intussusception or to gangrene of the intussusceptum and passage of the sloughed intussusceptum by rectum before the child had

died of the consequences of intestinal obstruction In such cases the tight adhesion of the intussusceptum and the intussusciens at the neck of the intussusception maintained the continuity of the bowel although there frequently resulted as a secondary manifestation either chronic intestinal obstruction from cicatricial stenosis or secondary perforation through the poorly healed area with peritonitis and death This is best described by Leichtenstern— Numerous trustworthy observations show that separation of the intussusceptum may lead to complete cure of the invagination But this mode of termination has many changes which threaten life The separation may take place too early before there is solid union at the neck of the invagination Perforation or rather rupture is the result or a part of the intussusceptum remains and causes a new invagination by increase of what is left in the old one In other cases constriction of the intestine takes place at the inactive line of separation increases more and more and often causes death after some years Finally torpid ulcers of the mucus membrane may remain at the place of separation and cause perforation long afterwards or defective nutrition as a result of diarrhoea Among the rarer illustrations we find death by septicemia—thromboses—metastatic abscesses in the liver—perforation and formation of a fecal cloaca

It is one of the ironies of medical progress that just at the time that Hutchinson was demonstrating the feasibility of operative reduction of intussusception in infants Hirschsprung of Copenhagen discouraged by the high mortality of intussusception instituted a plan of controlled hydrostatic pressure reduction of intussusception

Hirschsprung's first report was in 1876 By 1905 Hirschsprung was able to report on 107 personal cases of intussusception His results were so superior to those previously reported that his contemporaries doubted his conclusions He was forced in self defense to publish a paper reporting each of his 107 cases He presented a 95% mortality in a disease which up

injury of any kind to the intestine below or at the seat of invagination this experiment would tend to prove that insufflation can be practiced successfully in cases of invagination of several days duration. The pressure upon the rubber balloon should be uninterrupted and almost never exceed two pounds to the square inch. Disinvagination is effected by inflation by two distinct forces. In the first place the steady elastic pressure of the gas distends the bowel between the sheath and the returning cylinder which makes traction upon the neck of the intussusciens while the column of gas by its pressure against the apex of the intussusceptum acts as a direct reduction force.

Reduction was resisted after a time either by the swollen edematous intussusceptum or by adhesions of the neck of the intussusciens or between the serous surfaces throughout the invaginated portion of the bowel. From these observations I have come to the conclusion that reduction by gentle but efficient distention of the bowel below the invagination would succeed in the majority of cases if this procedure were practiced before either of the two principal conditions which cause irreducibility have had time to make their appearance.

By this time however the feasibility of operation upon infants with intussusception had been established.

Paul Barbette a surgeon of Amsterdam writing in the middle of the Seventeenth Century suggested that rather than allow patients with an intussusception to die it might be preferable to cut through the abdominal muscles and pull the invaginated intestines apart with the fingers. Nuck's case was reported by Haller in 1751. The patient was a woman of 50 who recovered.

The second patient known to have been operated upon for intussusception was an adult of 50 operated upon by Professor Ohle of Dresden and reported in 1817 by F. A. Fiedler. This patient died.

The third case and the second successful one was that operated upon by Fuchsius and report-

ed in Hufeland's Journal February 1825. This was a man of 28. Fuchsius not only operated successfully but opened the bowel to aid in the resection and sutured it so skilfully that no fecal fistula developed.

The first certain laparotomy for intussusception in a child was by Gerson and was reported by Hirschmann of Hamburg in 1840. This was a 12 week old infant. A good portion of the intussusception was reduced before gangrenous bowel suddenly delivered and tore with a fatal outcome.

The next recorded operation for intussusception was successful and was the first one in the United States. It was an operation performed by Doctor John R. Wilson of Tennessee and was reported by his pupil Mr. W. W. Thompson to the *Transylvania Journal of Medicine and the Associated Sciences* 1835 Volume 18 page 362. The paper is titled "A Case of Introsusception in which an Operation was Successfully Resorted to by John R. W. Wilson M. D. of Rutherford County Tennessee in December 1831." The patient was a negro slave who had failed to respond to the customary treatment of active purgation and metallic mercury by mouth. The reduction was easily effected at operation and the author concluded his recovery was rapid and entire. The success of this case in which the operation was so long deferred and at last performed under such unfavorable circumstances warrants the propriety of resorting to it in the disease and proves that relief may occasionally be afforded by this means when all others have failed.

Wilson's grandson O. H. Wilson Professor Emeritus of Pediatrics at Vanderbilt University School of Medicine reports the finding of Doctor John R. Wilson's day book with an entry for November 20 1831—\$5.00 for operation of Crisotomy on Chas. Dements. A boy with a record of several subsequent visits. A laconic enough memorandum of an historic operation.

There were a few other reported cases of operations for intussusceptions in adults and in infants among them unsuccessful operations in

England by Spencer Wells the renowned ovariectomist one of the founders of Gynecology and in Russia by Pirogoff the great military surgeon On November 11 1873 Jonathan Hutchinson read before the Royal Medical and Chirurgical Society his first paper on Intussusception reporting a successful operation performed in 1871 on a two year old infant referred to him by Warren Tay He stated—

Our first measure of treatment consisted in putting the child under chloroform and then whilst she was held up by the feet distending the rectum to the utmost with warm water

By this means the involted part could be forced up into the abdomen so as to be quite out of reach of the finger and once or twice I tried to hope the reduction had been effected On each occasion however when the lower bowel was allowed to empty itself the intussuscepted part became prolapsed as before and showed clearly that we had gained nothing

It was very evident from the child's condition that unless relief were afforded she would not live long and I therefore felt justified in telling the parents that although an operation would become in itself very dangerous yet I felt that it afforded the only chance

He made a lower midline incision withdrew the six inch long intussuscepted mass reduced the intussusception without any difficulty and replaced the bowel The operation had been an extremely simple one and had not occupied more than two to three minutes

From this time on although it is obvious intussusception was still an extremely grave disease and carrying in spite of all a high mortality it was considered a disease in which the outcome could be materially affected for the better by proper treatment Theretofore recovery following rectal injection had been irregular and uncertain and operation had rarely been attempted Such survivals as did occur were due in the main either to spontaneous reduction of the intussusception or to gangrene of the intussusceptum and passage of the sloughed intussusceptum by rectum before the child had

died of the consequences of intestinal obstruction In such cases the tight adhesion of the intussusceptum and the intussusciptens at the neck of the intussusception maintained the continuity of the bowel although there frequently resulted as a secondary manifestation either chronic intestinal obstruction from cicatricial stenosis or secondary perforation through the poorly healed area with peritonitis and death This is best described by Leichtenstern— Numerous trustworthy observations show that separation of the intussusceptum may lead to complete cure of the invagination But this mode of termination has many changes which threaten life The separation may take place too early before there is solid union at the neck of the invagination Perforation or rather rupture is the result or a part of the intussusceptum remains and causes a new invagination by increase of what is left in the old one In other cases constriction of the intestine takes place at the inactive line of separation increases more and more and often causes death after some years Finally torpid ulcers of the mucus membrane may remain at the place of separation and cause perforation long afterwards or defective nutrition as a result of diarrhoea Among the rarer illustrations we find death by septicæmia—thromboses—metastatic abscesses in the liver—perforation and formation of a fecal cloaca

It is one of the ironies of medical progress that just at the time that Hutchinson was demonstrating the feasibility of operative reduction of intussusception in infants Hirschsprung of Copenhagen discouraged by the high mortality of intussusception instituted a plan of controlled hydrostatic pressure reduction of intussusception

Hirschsprung's first report was in 1876 By 1905 Hirschsprung was able to report on 107 personal cases of intussusception His results were so superior to those previously reported that his contemporaries doubted his conclusions He was forced in self defense to publish a paper reporting each of his 107 cases He presented a 35% mortality in a disease which up



Fig 1 (a) There must of course arise a certain number of cases in which the early diagnosis is difficult. For such cases I believe that the x ray with bismuth injections may be very useful. During the last few months I have employed this method three times twice to see if I could facilitate the operation by causing partial reduction with enema and once for diagnostic purposes. Plate I was taken of an infant six months old who was brought to the hospital about 24 hours after the onset of symptoms. These consisted of intermittent attacks of abdominal pain followed by vomiting and bloody stools, with very little feces. The abdomen was not distended and the mass could be

very easily felt in the mid line just above the umbilicus. The diagnosis was of course simple but I had a bismuth injection given in hopes of causing partial reduction and thus facilitating the operation. This end was not accomplished. The position of the tumor remained unchanged but the plate shows very clearly how useful this procedure might be in a case where the diagnosis was difficult. Note the cervix like shape of the advancing part of the intussusception and how distinctly this is shown to be within the bowel by the bismuth clinging to the wall of the intussusceptum extending back over it. (W. L. Ladd, *Boston Med & Surg J.* 1913)

Aus der chirurgischen Universitätsklinik Rostock

Ein Fall von Invagination ileocecalis im Röntgenbilde

Von

Dr C Lehmann in Rostock

Im folgenden will ich kurz über eine Beobachtung von Invagination im Röntgenbilde berichten, die wir im November 1911, unmittelbar nach der Veröffentlichung von Haenisch über seine Methode des Wismutenlaufs auf dem Trochoskop (Munch med Wochenschr 45, 1911) machten. Leider ist die Platte verunglückt, so daß ich den Befund nur in einer Skizze wieder geben kann. Mir sind bisher entsprechende Fälle aus der Literatur nicht bekannt geworden, nach mündlicher Mitteilung hat Haenisch selbst einen ähnlichen gesehen.

Es handelt sich um einen 18jährigen Jungling, der seit drei Wochen an kolikartigen Schmerzen litt, Stuhl war abwechselnd angehalten und durchfällig und enthielt häufig Blut. Bei der Aufnahme am 18. November 1911 fand sich ein wurstförmiger Tumor im Epigastrium, der der Palpation nach dem Querkolon angehörte. Die Differentialdiagnose lautete auf Tumor oder Invagination, resp. beides.

Bei der Röntgenuntersuchung, die genau nach den Vorschriften von Haenisch ausgeführt wurde, füllte sich rasch das Rektum, die Flexur und das Descendens. Man sah die Wismutsäule, die zunächst noch keine Haustrennung zeigte, an der Flexur umbiegen und ins Querkolon fort schreiten. Nach einer kurzen Strecke machte sie halt, und das gefüllte Ende des Querkolons blähte sich mächtig auf. Es fiel uns auf, daß die Wismutsäule an der Stelle, wo sie das Hindernis fand, vollständig glatt abgeschnitten erschien und sich nicht etwa zapfenförmig zuspitzte, wie man das wohl bei einem stenosierenden Karzinom hatte erwarten können.

Es wurde nunmehr eine Aufnahme gemacht, die bei genauer Betrachtung noch etwas mehr zeigte, als das Schirmbild (vgl. Skizze), auch hier war die Wismutsäule plötzlich scharf abgebrochen — übrigens war inzwischen die Haustrennung hervorgetreten —, von den äußersten Ecken der Unterbrechungslinie aber setzten sich zwei schmale 0,5—1 cm breite

K o s t i t z & G a b l e r R ö n t g e n a b b i l d. XXI

71

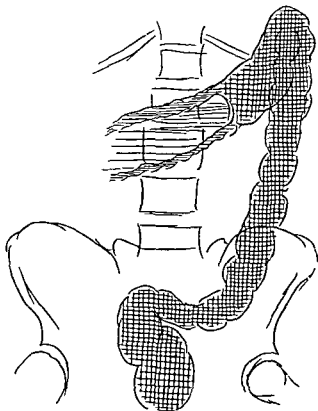


Fig 1 (b) Lehmann's report in 1914 of the use of bismuth enemata in diagnosing intussusception. He described the radiologic picture clearly, apologizing for the fact that the plate was poor and the sketch had to be substituted for it in publication. The observation had been made three years earlier in 1911. The patient was an 18-year-old boy

with a three-week history and a palpable tumor. Lehmann was apparently satisfied to have made the diagnosis. There is no mention of a therapeutic effort with the enema. The intussusception was successfully reduced at operation.

to that time was fatal in over 80% of the cases. In 81 patients treated by Hirschsprung with enema alone, the mortality was 23%. These figures compare favorably with those from The Johns Hopkins Hospital in the period from 1929 to 1938 more than 35 years later. Interest in the hydrostatic pressure reduction of intussusception has been maintained in Scandinavia ever since with from time to time, attempts to add transabdominal manipulation to it. In Australia, largely due to the influence of Hipsley hydrostatic pressure has been used with specific ulcer results.

The use of the x-ray in the diagnosis of intussusception was first suggested by Ladd in 1913 and by Lehman in 1911. Ladd stated—There must of course arise a certain number of cases in which the early diagnosis is difficult. For such cases I believe that the x-ray with bismuth injections may be very useful. During the last few months I have employed this method three times twice to see if I could facilitate the operation by crussing partial reduction with enema and once for diagnostic purposes. (Fig 1A). Ladd was convinced that this was a good diagnostic device and a useless therapeutic one. This was despite the fact that the improved mortality which he reported in this paper from the Children's Hospital in Boston was still 15%—higher than in Hirschsprung's series reported in the previous decade. Ladd himself ascribed priority of the use of the Roentgenogram in the diagnosis of intussusception to Lehman although Ladd's publication appeared earlier. Lehman does state that he was reporting an observation made three years earlier when his muh enemas were first described by Hrenisch. Lehman apologizes for the fact that his plate was so poor that a sketch (Fig 1B) had to be substituted for it in this publication. The result however is that Dr Ladd's report contains the first published photograph of the roentgenologic pictures of intussusception.

The use of the contrast enema to provide visual control of hydrostatic pressure reduction was a natural consequence of the introduction of

x-rays and this was reported simultaneously by Poulquien in France Olsson and Pihlin in Scandinavia and by Retan and by Stephens in this country.

The first successful resection of an intussusception in a child was that reported by Clubbe of Australia, in 1897 the second by Collinson of London ten years later.

The first successful resection of an intussusception in this country was reported by Petersen in 1908. Actually in the 21 years between 1896 and 1920 Clubbe could find only 15 reported instances of successful resection of intussusception in infants and it can well be assumed that very few successes had escaped report. One of the brilliant early successes was that of Dowd who in 1912 reported resection of terminal ileum and right colon in a five day old baby.

As it has a habit of doing in such matters time has affected the pertinency of most of the arguments for or against primary operative or primary hydrostatic pressure reduction. The evidence is overwhelming that from 1877 to 1915 the results in clinics employing hydrostatic pressure reduction were substantially superior to those obtained in the clinics employing operative reduction primarily. This was easily measured in terms of operative mortality. In the last decade, in the clinics with the greatest interest in surgical diseases of children deaths from intussusception have been limited essentially to those children hopelessly moribund at the time of admission irrespective of whether treatment was by operation or by hydrostatic pressure reduction. The argument is now based on subtler criteria which are discussed in detail in a later chapter.

BIBLIOGRAPHY

- Ashhurst John Jr. On laparotomy or abdominal section as a remedy for intussusception with tables showing the results of the operation in cases of this affection and in those of other forms of acute obstruction of the bowels. *Am J Med Sc* 45 1861 1871.
- Archamys Cechus. On Acute Diseases and on

- Chronic Diseases* Ed and Tr by I E Drabkin
Chicago Univ Chicago Press 1950
- Barbette Paul *Thesaurus Chirurgicae* 3rd Ed
London Moses Pitt 1676 p 324
- Clubbe C P B *The Diagnosis and Treatment of Intussusception* 2nd Ed Edinburgh 1907 London 1921
- Dowd C N Resection of one third of the colon for irreducible intussusception in an infant five days old *Ann Surg* 57 713 717 1913
- Fagge C H and Howse H G A case of intussusception in an adult without symptoms of strangulation treated successfully by abdominal section *Med Chir Tr London* 2nd Ser 41 89 98 1876
- Fiedler F A *Magazin für die gesammte Heilkunde* 2 253 1817
- Fuchsius C Ileus mit Unüberwindlicher Verstopfung, als Folge einer Einschiebung der gedarmen durch operation geheilt *Hufeland's Journal der practischen Heilkunde* 60 42 64 1825
- Hichmann A case of intussusception *Ztschr Ges Med* 14 289 303 1840
- Hipsley P L Intussusception and its treatment by hydrostatic pressure Based on an analysis of 100 consecutive cases so treated *M J Australia* 2 201 206 1926
- Hirschsprung H Et Tilfaelde af Subakut Tarminvagination *Hosp Tid* 3 321 327 1876
- Hirschsprung H 107 Falle von Darminvagination bei Kindern Behandelt in Königen Louisen Kinderhospital in Kopenhagen während der Jahre 1871 1904 *Mitt Grenzgeb Med Chir* 14 505 574 1905
- Holt L Emmett *The Diseases of Infancy and Childhood* New York Appleton 1897
- Hunter John On intussusception *Tr Soc Improvement of Med & Chir Knowl* 1 103 118 London 1793
- Hutchinson Jonathan A successful case of abdominal section for intussusception *Proc Roy Med & Chir Soc* 7 190 198 London 1873
- Hutchinson Jonathan Notes of a second case of abdominal section for intussusception into the colon with remarks on the details of the operation *Med Chir Tr Roy Med & Chir Soc* 2nd Ser 41 99 102 1876
- Ladd W E Progress in the diagnosis and treatment of intussusception *Boston M & S J* 169 512 514 1913
- Lehmann C Ein fall von invagination ileocaecalis in röntgenbilde *Fortschr Geb Röntgenstrahlen* 21 561 1914
- Leichtenstern O Intussusception invagination und darminschiebung *Ziemssen's Cyclopaedia of the Practice of Medicine* 7 610 624 1877
- Mitchell Samuel Intussusception in children *Lancet* 1 904 1837 1838
- Nuck Anton See Albertus Haller's Disputationes anatomicae selectae *Gott* 7 126 1751
- Olsson G and Pallin G Über das bild der akuten darminvagination bei roentgenuntersuchung und über disinvagination mit Hilfe von kontrastlavenments *Acta chir scandinav* 61 371 383 1927
- Pouliquen M et De La Marnierre Indication du lavement bismuthe dans certaines formes d'invaginations intestinales *Bull et mem Soc Nat de Chir* 50 1016 1021 1927
- Power D Arcy The Hunterian lectures on the pathology and surgery of intussusception (abstract) *Brit M J* 1 381 453 514 1897
- Power D Arcy Some points in the minute anatomy of intussusception *J Path & Bact* 4 181 1897
- Ravitch Mark M Jonathan Hutchinson and intussusception *Bull Hist Med* 25 342 353 1951
- Retan G M Non-operative treatment of intussusception *Am J Dis Child* 33 765 770 1927
- Senn N *Intestinal Surgery* Chicago W T Keener Co 1893
- Smith J Lewis *A Treatise on the Diseases of Infancy and Childhood* Philadelphia Lea 1872
- Stephens V R Ileocecal intussusception in infants with special reference to fluoroscopic findings *Surg Gynec & Obst* 45 698 700 1927
- Stephens V R Acute intussusception manipulation reduction under fluoroscopic control *Am J Dis Child* 35 61 64 1928
- Thompson W W A case of intussusception in which an operation was successfully resorted to by John R W Wilson M D of Rutherford County Tennessee in December 1831 *Pennsylvania J Med* 3 486 1835
- Treves F *Intestinal Obstruction* London Castle & Co 1901
- Wilson O H Intussusception in 1831 *J Tennessee M A* 42 53 54 1919

THE CLINICAL PICTURE OF INTUSSUSCEPTION

THE INTUSSUSCEPTION

The muscles of the bowel wall are strong
And by their strength they force the food along
In rhythmic waves contractile come and go
Making the intestinal contents flow
As if through any kind of morbid state
A bit of bowel wall invaginate
The muscle wall may force it on and on
Until far down the lumen it has gone
The gut below dilates for its reception
In it thus you get what is called intussusception

The process starts from undue stimulation
Induced by so ne slight cause of irritation
A swollen liver's patch a small lipoma
A Meckel's process or a papilloma
Or just a piece of solid food in gut
Where n before such food had ne'er been put
This statement to the striking fact gives meaning
—At intussusceptions co-ic at time of ucaning

Behold a year old bouny lal y boy
His father s pride his mother s constant joy
In resifal sleep—quite healthy it uould seem—
When suddenly he wakes up with a scream—
His pink face pales his pupils may dilate
He draws his legs up for the pain is great
But in a while the spasm seems to cease
And once again he may have sleep in peace
Yet not for long for soon he wakes again
The pain and screams recur and he may strain
And pass some blood stained mucus on his nappie
Thus renders loth his parents much unhapfy
And so they call the doctor to their aid
Of something serious they are soon afraid

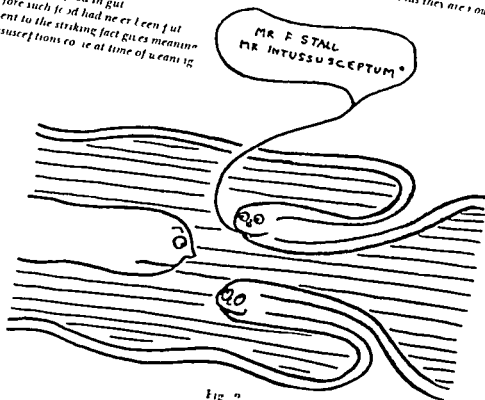


Fig. 2

*The doctor with his gentle nice warm hands
 Palpates the belly as the case demands
 The R.I.F. feels empty (Signe de Dance)
 But higher up his search reveals perchance
 A swelling rather sausage like which oft
 Gels sometimes harder sometimes lax and soft
 It may be felt in epigastrium
 Or one or other hypochondrium
 Or sometimes it may very slowly slide
 Low down towards the pelvis on left side
 Then may a finger in the rectum put
 Feel the soft apex of advancing gut
 And on the withdrawal finger will be found
 Some blood and mucus smeared all around*

*Sometimes the doctor will be horrified
 To see a fleshy mass protrude outside
 And then the long soft swelling may perhaps
 Be easily mistaken for prolapse
 But if you put your finger in the rectum
 It goes inward and intussusceptum
 But not with prolapse—for there is a septum*

*The colon as you know a common site is
 For inflammation—here known as colitis
 Which may from time to time cause doubt I fear
 For blood and mucus may in stools appear
 But usually the pain is not so severe
 And since the motions will show faecal stuff
 These points distinctive should be quite enough
 (Though colitis inflammation oft may render
 The whole course of the colon to be tender)*

*Not long ago the doctor when in doubt
 Would give an anaesthetic to find out
 If there were any tumour on palpation—
 If so then that was clearly confirmation
 But in these days there is a better way
 Which may the need for anaesthetic stay
 For if an enema of barium
 Be flowed into the bowel per anum
 And then observed minutely by x rays
 As it ascends the colon's winding ways
 One then can see if there's imagination
 And not depend upon imagination
 This means a radiologist
 Should often be consulted to assist*

From ZETA *The Acute Abdomen in Phylae*
 Reproduced with permission of the publishers
 H. K. Lewis & Co. Ltd

INCIDENCE

The classical case of intussusception occurs in the well nourished male child eight months old who is awakened from sleep with what appears to be violent abdominal pain flexes his thighs cries out vomits and passes a normal stool. Thereafter he vomits repeatedly has obvious bouts of recurrent peristaltic pain and begins to pass bloody mucus per rectum. Before long he becomes apathetic pale and soon presents evidence of dehydration. The intestinal obstruction which has existed from the first moment does not become manifest for many hours. The condition is fatal in three to five days if not interrupted. The intussusception begins at or near the ileo caecal valve. Examination of the bowel shows no obvious local anatomical cause for the intussusception.

This is the classical picture and so typical that the diagnosis may frequently be made over the telephone and is commonly made by the dispensary nurse on the patient's arrival in the Accident Room or Outpatient Department. However the variations of the picture are of some interest and are of great importance in permitting the diagnosis of the atypical cases which are the only ones in whom a fatal issue is at all likely today.

Intussusception seems to be appreciably more common in some parts of the world than in others. At the Johns Hopkins Hospital where at the Harriet Lane Home there is an extremely active Outpatient Department and where we have long had a special interest in intussusception we see no more than six to eight cases a year. It does not appear that other clinics in this country see appreciably more. At the Denver Children's Hospital (Packard and Allen) there were 55 cases in ten years. At the Children's Hospital in Los Angeles (Snyder Kraus and Chaffin) 143 cases in ten years. At the Charity Hospital in New Orleans (Kahle) 54 cases in eleven years. In Milwaukee at the Children's Hospital (Thatcher) 60 cases 1917-1923. The Children's Hospital in Boston (Gross) where there is exceptional clinical experience in all fields of pediatric surgery saw 258 cases in the thirteen years 1931 to 1947 not quite twenty per year. The Children's Hospital in Cincinnati (Hing) reports 12 cases 1947-1952. Babies Hospital in New York (San

tulli and Ferrer), 41 cases 1919-1951 both about eight cases per year. The Children's Memorial Hospital in Chicago (Fox) had 90 cases 1915-1956 only ten per year and the St. Louis Children's Hospital (Thurston Holowach and McCoy) 116 cases in the seventeen years 1934-1951 or again only seven per year. In contrast with this American experience one unit of the Royal Hospital for Sick Children in Glasgow (Dennison) in the ten years between 1937 and 1946 admitted 237 cases of intussusception—23 to 24 cases per year. From 1946 to 1956 Dennison has had the great total of 399 cases almost 40 each year! Helmer's material from the University of Lund covers 162 cases seen in three years 54 cases per year. Nordenfolt of Copenhagen collected 440 cases of intussusception between 1928 and 1935 63 cases per year.

There have apparently been very few precise statistical studies of the incidence of intussusception. In the absence of such comparable statistics one should perhaps have some reservation in asserting that intussusception is a good deal more common in Britain and in Scandinavia than in the United States. McMahon has made a unique study of intussusception in the city of Birmingham, England using a biostatistical approach. In the entire city of Birmingham he found for the ten year period 1915 to 1924 296 confirmed cases of intussusception in children under the age of ten years in incidence of 1.19 per 1000 live births. Spence and Court for the five year period 1911 to 1919 in Newcastle-on-Tyne found 127 cases in incidence of .38 per 1000 live births. In both studies in the later years of study it was found that the number of cases located was appreciably higher possibly the result of improved ascertainment.

Sex

In our analysis of 152 cases at the Johns Hopkins Hospital 62% of the intussusceptions were in male children and 38% in female children. This figure agrees closely with the figures of

61.2% male for Birmingham (McMahon) 68% in London (Perrin and Lindsay) 61.1% in Sydney Australia (Hipsley) 60% in Los Angeles (Snyder *et al.*). The ratio of three to two seems to be fairly constant although in our next 17 cases 1952-1958 the incidence has been 22 males and 25 females presumably a temporary statistical aberration which further experience will correct. No satisfactory explanation has been offered for this male preponderance. McMahon offers an interesting analysis of the sex ratio at different ages. Below the age of nine months males are only slightly in excess of females 55.4% after nine months, the excess is very marked 77.7%. He found the difference in sex ratio between these two periods to be 22.3 plus or minus 5.6 which was significant.

Race

In our original material 63.1% were in white children and 36.9% were in negro children. Since the proportion of negro to white dispensary visits was 60 to 40 it suggested that intussusception is somewhat more common in white than in negro children. In our next 17 cases 17 were white and 10 negro reflecting the change in dispensary population. At the Charity Hospital in New Orleans Kahl reports the racial incidence to be proportional to the hospital admission rate.

Age

As seen in Figure 3 intussusception occurs largely in the first year of life and in that year most commonly in the period from the fifth to the ninth month. Of our total of 199 cases 57% occurred in children who were four to eleven months of age. This is below the figure of McMahon who found that in Birmingham 62% of the patients were under one year of age.

Dennison reported from the Royal Hospital for Sick Children in Glasgow 73% of 172 cases under a year of age. This lower age incidence is characteristic of reports from purely pediatric hospitals. In our material the peak of incidence appeared to be in the seventh and eighth

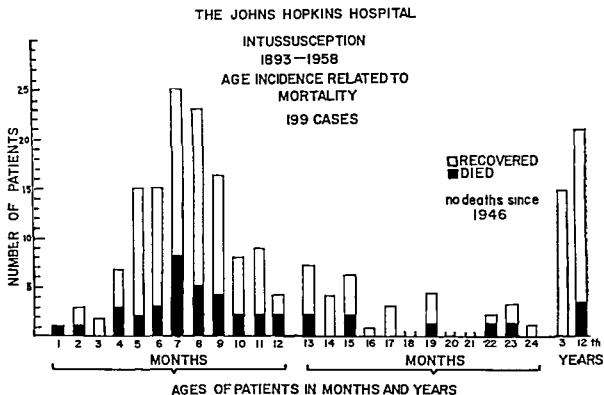


Fig 3 The peak of the incidence is in the fifth to ninth month age period and 59% of the intussusceptions occurred in children from four to eleven months of age

Over 80% of the children were under two years of age. In the days when deaths occurred the mortality was high in the youngest infants

months. This is somewhat later than the incidence in MacMahon's series, which was highest in the period through the sixth month. Dennison found 102 cases under six months of age and 70 cases between six and twelve months of age. Again a somewhat earlier age incidence by months than our own. A number of other reports. Perrin and Lindsay Hipsley show the peak of incidence at five or six months.

Intussusception in the newborn infant is of special interest. Rachelson reviewed almost six thousand reported cases of intussusception in the literature and found that three tenths percent had occurred in the first month of life. In the past 150 years 28 cases were reported in the first month of life, 18 of them in the first week of life. Most of the babies were mature, full term infants in good vigor. The symptoms were in no wise unusual.

Intussusception has been quite clearly shown to occur in utero and to be a cause of intestinal

atresia. The reason for the development of the intussusception in the fetus is unknown, but the resulting gangrene produces destruction of the bowel and a fibrosis which gives the appearance of a congenital failure of formation of a segment of bowel. However, in the distal segment of bowel in such cases the end of the intussusceptum can at times be found, and the presence of lanugal hairs and squamous cells of the vernix caseosa in the distal segment all indicate that the bowel had at one time been patent.

Season of Year

Some writers have noticed a seasonal variation in the incidence of intussusception, usually finding the incidence maximal in the summer months and attributing this to the greater frequency of gastroenteritis in such seasons. As seen in Figure 1 in our material, there appears to be a sustained peak from March through August and another in December through January, conceivably reflecting the periods of enteritis and of

SEASONAL VARIATION OF INTUSSUSCEPTION

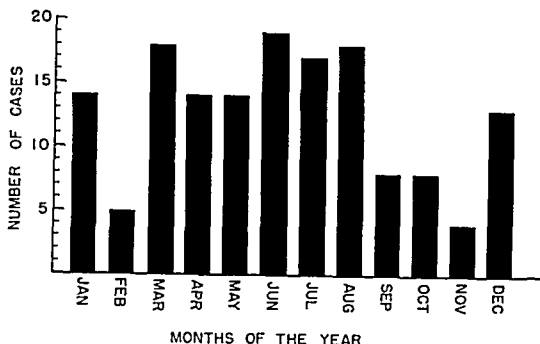


Fig 1 There is an apparent sustained peak March through August and another in December through January conceivably reflecting the maximal incidence of

enteritis and of respiratory infections. (From Ravitch and McCune *J Pediat* 3: 1950)

upper respiratory infections. As noted the maximal incidence of intussusception is in the seventh and eighth months of life in our material. This seasonal variation in the incidence of intussusception does not merely reflect a corresponding peak in the local birth rate seven to eight months previous since the number of live births in Baltimore from month to month year in and year out varies by no more than plus or minus 1%. Bolling found intussusception most common in the summer months. Close confirms this finding for younger children but found in his material that after one year of age the condition was most common in the months of December through March. Fitzwilliams found a high incidence in March and December and Perrin and Lindsay report peaks of incidence in April and January but Hogg and Donovan and Hipsley found little or no seasonal variation. MacMahon found no evidence of seasonal variation in his study of the total incidence of intussusception in the city of Birmingham.

Birth Rank

We have previously noted that a surprising number of our patients occupied the higher birth ranks in their families although on the contrary Wakely and Atkinson and Hogg and Donovan found a high percentage of patients who were first born. MacMahon studied his intussusception series and a comparison sample with respect to birth rank and to maternal age and found no significant differences.

There is no evidence that there is any increased likelihood of intussusception in a sibling, once one child of the family has been affected. This of course does not include the instances of intussusception occurring in the occasional family with inherited multiple polyps in the small bowel.

Nutrition and Previous Health

Intussusception tends to select sturdy well nourished infants. The tendency for good nutrition is so outstanding that Hirschsprung

could say— Ich erinnere mich auch nicht jemals bei einem atrophischen Kind eine invagination gesehen zu haben. Of 119 of our 152 cases in which notation was made of the state of nutrition in 98 it was said to be good in eleven fair and in ten poor. Illingsworth and Dick offer the somewhat hypothetical suggestion that in vigorous male infants with strong musculature the tone of the bowel muscle is greater than its ability to relax the motor mechanism develops before the inhibitory one and in early infancy the parasympathetic nerves are relatively weak.

With respect to previous health in 119 out of 189 cases in which the histories were adequate it was found that previous health had always been good. In 23 cases diarrhoea had been noted previously in 13 cases constipation had been a prominent feature and in ten cases there had been symptoms of intussusception on previous occasions. Search of the history for common predisposing causes was not particularly fruitful. There were 23 children who appeared to have definite bouts of diarrhoea before a sudden change in the character of the symptoms indicated the onset of intussusception. Four children had received cathartics for constipation just before the onset of symptoms and three others had been severely constipated. A good many of our children had upper respiratory infections. Of the last 47 7 had severe upper respiratory infections. However Dennison states— On comparing notes with our medical colleagues we found no relationship between intussusception and seasonal diarrhoea but an almost constant relationship with upper respiratory infections. As non specific mesenteric adenitis usually follows upper respiratory infections and mesenteric adenitis is common in intussusception it is reasonable to assume that the lymphoid hyperplasia involves Peyer's patches and the collar of lymphoid tissue which is so marked in the terminal ileum of infants.

It is frequently stated that the high incidence of intussusception in some European countries

is associated with the fact that children there are more frequently breast fed and that the subsequent change from breast milk to cow's milk plays a part in the occurrence of intussusception. The possibility that this is a factor or that the change from milk to a more solid diet alters peristalsis so as to initiate an intussusception can be no more than guessed at.

Previous Attacks, Spontaneous Reduction

It may well be worth emphasizing the fact that of our first 152 patients ten had histories which clearly indicated previous attacks of intussusception with spontaneous recovery. This is not often commented upon in reports on intussusception and we were unprepared for this finding. The intervals between previous attacks and the intussusception which finally brought the patients to the hospital varied from ten days to six months.

It is significant that nine of these ten children were operated upon (most of these cases were earlier in the series) and of these nine in three polyps were found and removed. It is probable that an operative search for polyps should be made whenever there is a strong history of previous attacks. One of the few discussions of spontaneous reduction of acute intussusception in children is that of Goldman and Ellman in 1940. They presented five cases of intussusception four in children much older than the usual group in whom they felt there was good evidence of spontaneous reduction of one or several attacks of intussusception. Three of these children were operated upon and found to have no inciting cause such as tumor or Meckel's diverticulum. Actually in one instance the history was of two weeks' duration with intermittent attacks of pain and another was of one week's duration. While these two cases and very possibly a third of Goldman and Ellman's five cases represent chronic non strangulating intussusception rather than repeated recurrences certainly every surgeon has had the experience of operating for an obvious intussusception only to find that it had reduced spontaneously some

time between the last examination of the abdomen and the opening of the peritoneal cavity.

Kahle found five instances of spontaneous and complete reduction of intussusception in 71 cases. Thurston *et al.*, list 15 patients with the clinical diagnosis of intussusception eight of whom were not operated upon because of apparent spontaneous reduction or inadvertent reduction by diagnostic barium enema. In an additional seven patients operation confirmed spontaneous reduction. It is not stated how many of these patients with spontaneous reduction had had diagnostic barium enemas and this may merely represent a testimonial to the ease with which some intussusceptions are reduced by barium enema. The same report presents one additional case of well documented spontaneous reduction of an intussusception. Jones from Newcastle on Tyne reported six spontaneous reductions in 103 cases. MacFarlane and Thomas cite four cases of recurrence of intussusception after operative reduction and during the same hospital admission.

Santulli reports a 5% overall incidence of recurrence since 1923. In his 41 most recent cases there were four recurrences: one a month after barium enema reduction confirmed at operation; another five months after barium enema reduction confirmed at operation; and another 24 hours after barium enema alone. The fourth recurrence was four months after primary operative reduction. Fox reports a recurrence rate of 1% in 90 intussusceptions operated upon at the Children's Memorial Hospital in Chicago, exclusive of one child with multiple polyps who required four operations. Court and Jones report that in 16 of their 124 children all operated upon primarily, an incidence of almost 1% recurrences occurred. In one of these children recurrences occurred on five occasions in one on three occasions in two on two occasions and in the rest on one occasion.

Spontaneous Sloughing of the Intussusceptum

From the earliest days it has been known that in some instances the intussusception be-

comes gangrenous and sloughs, the bowel fusing at the neck of the intussusception and retaining its continuity. The intussusceptum is passed by rectum and recovery ensues. At times such recovery is permanent but in some instances late perforation occurs in the line of fusion of the proximal and distal intestine and in other instances a progressive cicatricial constriction occurs at this spontaneous anastomosis producing intestinal obstruction once more. Today such instances of sloughing of the intussusception are only rarely seen and under conditions of gross neglect and misdiagnosis or in the absence of medical care. In earlier days such a spontaneous passage of a gangrenous and separated intussusception was the patient's only hope and as late as 1906 Harvey Cushing recorded in the history of a child with an intussusception that operation was postponed in the hope that sphacelation might take place and the sphacelus be passed entire per rectum. In contrast to the rarity of such cases today, Leichtenstern in 1894 reported 42 collected cases of spontaneous resolution of intussusception by sloughing. The bowel sloughed in periods varying from 11 to 21 days after the onset of the intussusception and the separation was usually ileal. Such instances were rare in infants and occurred chiefly in older children. Treves described the mechanism of the slough setting out to explain the observation that at times the slough was passed with the mucosa side out and at times with the mucosa side in. He concluded that if the innermost loop of bowel separates first the intussusceptum will completely evert itself within the bowel so that it will be mucosa out and serosa in and when finally the returning layer of the intussusceptum separates the segment is passed essentially inside out. If the returning loop separates first at the neck of the intussusception it is passed down over the entering loop until the entire intussusceptum lies extended in the bowel, serosal side out and passes when the entering loop separates at the neck.

A remarkable case is reported by Richelson

of a newborn infant which at the age of 30 hours passed an eight centimeter length of gangrenous bowel mucosal side out. The child became obstructed and a lipiodol enema showed a typical intussusception at the mid transverse colon which was reduced to the terminal ileum where complete obstruction to the further flow of contrast material occurred. Operation was undertaken when the baby was 56 hours old. Incredibly the ileum was found completely divided and both ends sealed off. The only possible explanation is that this was a gangrenous intussusception part of which had sloughed and that the lipiodol had reduced so much of the intussusception as remained allowing the two ends of the bowel to separate and that in a newborn these ends were able to seal off for the 24 hours between the lipiodol enema and the operation.

SYMPTOMS

The chief complaint in 44% of our cases was vomiting and in 42.8% of the cases was the passage of blood per rectum. The patients being largely infants only 25.7% of the mothers considered abdominal pain the chief complaint. In some instances pain and vomiting or pain and bleeding or vomiting and bleeding formed joint chief complaints. In the remainder of the cases prolapse of the intussusception distention constipation diarrhoea fever prostration and many other symptoms were variously given as the chief complaints. The symptoms of onset tend to differ somewhat from the presenting symptoms at the time the infants are seen. As seen in Fig 5 evidence of abdominal pain announced the onset of intussusception a little more frequently than did vomiting 98 out of 199 or 49% as compared to 66 out of 199 or 31%. The appearance of blood per rectum was the first symptom in only 23 out of 199 or 12%. As might be expected pain is increasingly the first symptom in successively older age groups while blood in the stool is the first recognized symptom almost solely in infants in the first two years of life when the less dramatic symptoms may not command the mother's attention.

SYMPTOMS OF ONSET
199 Cases of Intussusception

	0 To 2 (Yrs of Age)	Two & Over (Yrs of Age)	Entire Group
Pain	69/161—43%	29/38—76%	98/199—49%
Vomiting	63/161—39%	3/38—8%	66/199—31%
Blood	20/161—12%	3/38—8%	23/199—12%
Refusal to eat	8/161—5%	1/38—3%	9/199—4.5%
Prolapse restlessness diarrhoea constipation distention nausea listlessness fever and convulsions were the first symptoms recognized in the remainder of the cases			

Fig 5 Pain is the commonest symptom at the onset of intussusception vomiting next and bloody rectal discharge third. In the infants pain was not appreciated by the parents as frequently as in the more articulate older children.

Pain

A history of apparent pain at some point in the course of the disease was obtained in 60.7% of infants under one year of age and in 81.8% of the infants one to two years of age and 91.3% of the children over two years of age. This presumably reflects equally on the articulateness of the patients and the perceptiveness of the mothers. Gross and Ware report that rhythmic pain was observed in more than 90% of their cases. Kahle states that pain was present in every patient and was the first symptom in all but two of his series. Nordentoft noted pain at some time in 98% of his cases and again the only patients in which no pain is reported to have occurred were the youngest infants.

Vomiting

In all 92.8% of the children vomited before treatment was begun. In the patients under the age of two years vomiting occurred at some time in 91.6%. In the children two years of age and over 92.6% vomited. As to the relationship of vomiting to the time of onset of symptoms it is found that 73% of the infants under two years of age who vomited began to vomit in the first three hours of the disease while in the children over two 52% vomited in the first three hours. It would appear then that vomiting occurs most uniformly in the younger infants and in these infants vomiting tends to be earlier in the

course of the disease. This early vomiting is of course reflex vomiting. The vomiting of intestinal obstruction is a late sign which should never been seen in an intussusception which has been properly handled.

The feeding history of the children after the onset of symptoms is of interest. Only nine of 112 in whom data are available took food and retained it but 47 out of 112 took food when it was offered after the onset of symptoms although they proved to be unable to retain it.

Blood

In all blood was seen in 91%. In 95% of the patients under two years of age blood had been observed in stools or in the rectum but in only 63% of the patients over two years old. In all 59% of those who showed blood at all ages showed blood in the first 12 hours and 37% of those showed blood in the first three hours. There appears to be little difference in the appearance time of blood in the stool in the two age groups but the younger children are more likely to show blood than are the older ones. The blood was prominently mixed with mucus in the majority of the cases. At times the passage consisted almost entirely of mucus which was produced with only a slight admixture of blood and occasionally with blood detectable only under the microscope. In some instances the passage was a thin mahogany colored fluid. A few white blood cells were not uncommonly seen in the stool but it was uncommon to see actual pus. In many cases blood was detected only on the examination, further emphasizing the necessity for rectal examination. In Thrasher's series blood was found in 61% of the patients; in Cross's series in 81% in Thurston's in 80% and in Kahles in 90%. Nordenfolt found passage of blood from the bowel in 88% of the patients under two years of age and in 38% of those above that age.

Constipation

In 13 of the 132 cases constipation was noted as a complaint more commonly in the less articulate younger patients. The absence of stools

after the onset of symptoms is a negative symptom of some importance although it is not uncommon for the patient to evacuate his bowel shortly after the onset of intussusception.

Diarrhoea

Diarrhoea after the probable onset of intussusception occurred in 13 or 65% of the 199 cases. Eleven of these thirteen patients were under one year of age. This symptom may occur when obstruction to the bowel is still incomplete. Two of these 11 patients did not have a palpable mass on physical examination. Diarrhoea occurs in intussusception with sufficient frequency to make it wise to consider the diagnosis of intussusception in infants presenting an atypical clinical picture of dysentery. Of these 13 patients six were actually first mistakenly diagnosed as having dysentery and three died as a result of the ensuing delay.

Prolapse of the intussusception through the anus occurred in seven children an incidence of 3.5% with no apparent predilection for any one age. Cross and Ware found six cases of prolapse of the intussusception outside of the anus in their series of 610. In Kahles' 1931 report of 51 cases prolapse of the intussusception through the anus had occurred in two.

Distention as a complaint was rare being made only three times in all each time in an infant. Listlessness, drowsiness, prostration were noted by all mothers in 30% of all cases with no variation in distribution in the age groups. Only one mother had felt a mass in her child's abdomen.

EXAMINATION

Fever

There were 97 children under one year of age in whom there were data on the temperature and of these 41 out of 97 or 42% had a temperature of 101°F or above at the time of admission. 28 out of 97 or 29% had temperatures of 102°F or over and 12 out of 97 or 12% 103°F or over. In the one to two year age group six out of 19 or 32% with data had temperatures of 101°F or over and in the group over two years

of age three out of 21 or 14% had a fever of 101°F or over

Fever is both commoner and higher in the younger patients

There were 35 fatal cases (all fatal cases were prior to 1946) in which the admission temperature was recorded. There were 15 children who had temperatures of 103°F or over on admission and 11 of these 15 73% died. There were four who had a temperature of 104°F and these four all died. Of the fatal cases 23 out of 35 or 66% of the patients had a temperature of 101°F or over. Thus the presence of high fever was of very grave prognostic significance although in a third of the fatal cases in which there were data the patients had temperatures below 101°F.

In the records of the patients before the reduction of the intussusception pulse and respirations are not regularly noted and no statistical studies could be made. In both features the trend is toward elevation.

White Blood Cell Count

Of the 109 cases in which the white blood cell count is recorded before treatment the count was 12 000 or over in 60% and 13 000 or over in 53%. In 17% the white blood cell count was 20 000 or over.

Of the patients who died the leucocyte count before treatment is recorded in 21. Of these 14 out of 21 or 67% had counts of 12 000 or higher but since 51 out of 88 or 50% of the survivors with data on white blood cell count had counts of 12 000 or over leucocytosis is of no prognostic significance.

Prostration

Many of the prostrated children were cold and sweaty some unresponsive all of them torpid apathetic knocked out.

Of the total of 199 cases in our earlier report the history permitted evaluation of this symptom in 137. Of this group 66 or 137 or 48% presented the appearance of prostration. Of the 76 showing little or no evidence of prostration nine died. Of the 66 noted to be prostrated 28 or 42% died. In six of the fatal cases data was

lacking as to prostration. Obviously the signs of torpor and depression are indicative of graver progression of the disease. There is no important variation in the significance of this symptom in the three age groups. In our additional series of 47 cases 14 were severely prostrated and interestingly enough the only child in the group with an irreducible intussusception was not particularly prostrated.

The appearance of prostration is fully directly related to the duration of symptoms. Of 79 cases of prostration in which data were adequate—

8 instances of prostration occurred in 44 patients (19%) who were ill less than 12 hours
13 in 35 patients (37%) in the 12 to 24 hour group
14 in 31 patients (45%) in the 24-36 hour group
10 in 13 patients (77%) in the 36-48 hour group
11 in 24 patients (46%) in the 48-72 hour group
11 in 20 patients (55%) in the 72-96 hour group
12 in 26 patients (46%) in the 96 hour and over group

As we shall see in the analysis of the relation of duration of symptoms to mortality there also is seen there a steady progress up to 96 hours after which there is a levelling off and a decline. This is explained by the generally earlier application for treatment of the severe cases and the selective survival of the non strangulating cases.

Dehydration

Dehydration was found to be marked enough to be noted in 51 out of 121 (42%) of cases in which there were adequate data prior to 1918. Of these 21 or 41% died. There was no significant difference between the infants and the older children. Of the 73 children who were not dehydrated 8.73 (12%) died. Adequate data regarding dehydration were not given in 14 children who died. It seems clear that had adequate data been available in this group the grave prognostic significance of dehydration would be even more strongly emphasized for as it is only eight patients died in whom the absence of dehydration was recorded on admission.

Associated Diseases

It appears noteworthy that at the time of admission in 11/190 cases or 21% of the patients in whom there were adequate data there was found either otitis media or an upper respiratory infection or both on the admission physical examination. A number of authors have suggested that enlarged mesenteric nodes may be associated with upper respiratory infections and in their turn cause intussusception. Recently we have seen at another hospital an intussusception in a child with florid chicken pox.

Examination of the Abdomen

In a child with the characteristic picture of intussusception the abdomen early in the disease is flat or actually scaphoid. The intussusception occasionally forms a protuberance which is visible. Typically the abdomen is very soft and non-tender although the child may wince when the intussusception is palpated and in such instances there may then be felt a little muscular resistance over the mass. Palpation of the intussusception is the surest diagnostic sign and one should expect to palpate the tumor almost invariably. Early in the progress of a characteristic intussusception the mass passes into the hepatic flexure behind the right costal margin and under the right lobe of the liver where it may be difficult or impossible to feel for some time. As time passes the disease picture is confused by the superimposition of the non-specific signs of intestinal obstruction—distention and intestinal patterns which may obscure the mass. In a number of instances the mass was not definitely palpable until thrown into prominence by vigorous peristalsis during a cramp. An intussusception palpable before such peristalsis is felt to be much firmer at such a time. The mass is usually described as tubular, sausage-shaped or cylindrical. The pull of the mesentery on the intussuscepted bowel between the layers of which it has been drawn constrains the tumor to arch in a curve.

Abdominal Resistance

Some 60% of the patients were said to show

complete relaxation of the abdominal wall with no resistance or spasm anywhere. Some resistance even though only over the mass was noted in 40%. Tenderness was noted in 41% of those with adequate data. In most of these the tenderness was noted directly over the mass. It will be seen that the figures are almost identical for the incidence of resistance and of tenderness. Presence or absence of distention was remarked upon in 186 cases. In 51/186 or 29% a rather higher incidence than might be expected distention was present. This is a reflection of course of the duration of the disease and of the appearance of signs of intestinal obstruction.

Mass

Data were adequate in 196 cases. In 167/196 or 85% a mass could be felt either abdominally or rectally. In most cases if a rectal mass was palpable an abdominal mass was felt as well but in ten of the cases in which a mass was felt it was felt only per rectum. In an occasional patient the abdominal mass was plainly visible. Thrasher reports a palpable mass in 85% Cross in 85%, Thurston in 72% and Kahle in only 59%. A mass on palpation was found in 60% of Nordentoft's children under two years of age and in 73% of the older children. Snyder *et al* found a mass in only 69%.

Peristalsis

Mention of presence or absence of visible peristalsis was made in 113 cases. It was noted to be present in 21/113 cases or 18%.

Prolapse

In 7/199 or 3.5% of the cases the intussusception presented at the anus or beyond. It is customary to warn against mistaking a prolapsed intussusception for a mere rectal prolapse in which latter obviously the finger cannot be passed between the prolapsed bowel and the sheath of the intussusception quite apart from the wide difference in the clinical picture in the two conditions. Other series report a substantially lower incidence of prolapse.

DURATION

The age of the pathologic process is an obvious determining factor in the production of necrosis of the bowel and other physiologic disturbances. It is of interest therefore that while in the last thirty years the promptness with which children with intussusception are brought to our hospital has indeed changed somewhat for the better our hospital mortality for the disease has first improved and then been eliminated without obvious reference to the modest decrease in the average duration of symptoms. A few cases of more than seven days duration are accepted as being typical chronic intussusceptions which might weight the results. In the period 1893 to 1909 patients averaged 56 hours from the onset of symptoms to beginning of definitive therapy and in the period 1910 to 1919 the time was 54 hours. In the next decade 1920-1929 there was substantial improvement to 45 hours. However the periods in 1930 to 1938 and 1940 to 1948 were still 28 hours and 38 hours. In the decade 1948-1958 the period from onset of symptoms to institution of treatment was 25 hours after we excluded from the computation three cases of chronic intussusception of 53, 22 and 21 days. Retained were two of 96 hours duration, one of 84 hours and three of 54, 52 and 50 hours (Fig. 6).

DURATION OF SYMPTOMS AT VARIOUS PERIODS AND MORTALITY IN THOSE PERIODS

Date	Onset to Treatment (Hours)	Mortality
1893-1909	56	75
1910-1919	54	71
1920-1929	45	41
1930-1938	28	29
1939-1948	38	94
1949-1958	25	0

Fig. 6 One Hundred and Ninety nine Intussusceptions in the Johns Hopkins Hospital—1893 to 1958. There was a fairly steady decrease in the elapsed time from onset of symptoms to the institution of definitive treatments from 1893 (56 hours) to 1938 (28 hours) and a drop in mortality from 75% to 29%. Since then there has been little change in the duration of symptoms but a decrease in mortality from 29% to 0.

Figure 7 shows the relation of Mortality to the Duration of the Disease before the onset of definitive treatment. The current mortality is so low (in The Johns Hopkins series—no deaths 1946-1958) that it is only in the study of our earlier cases that this sort of information can be elicited. It is obvious that there is direct relation between the duration of disease before the onset of definitive treatment and mortality until one reaches the group with symptoms of 96 hours duration or longer. It is apparent that many of the children still alive with intussusception untreated for over four days must have had non strangulating obstructions and that these carrying a better prognosis than the ordinary intussusceptions tended to decrease the mortality in this group. Only 4/52 children treated in 24 hours or less succumbed a mortality (1893-1948) of seven per cent. In the 24 hour to 48 hour group 10/37 died or 27%. In the children in the 48 to 96 hour group 20/37 died a mortality of 54% but in children not definitely treated until 96 hours after the onset of symptoms only 7/23 died or 30%.

OCCURRENCE OF SPECIFIC LESIONS CAUSING INTUSSUSCEPTION

In our first 152 cases eight specific causative lesions were discovered. In five there was a polyp in two there was a Meckel's diverticulum in one an ectopic focus of pancreatic tissue. In the 47 intussusceptions since 1918 we have encountered one small enteric cyst at the ileocecal valve causing intussusception, three Meckel's diverticula and one unusually large discrete patch of ileal lymphoid tissue leading an intussusception. The total for the 199 cases is thus 13 such lesions an incidence of 6 1/2%. It is significant that only three of these patients were less than one year old. Three were over a year old, one was two years old, one 2 1/2, one 3 1/2, one 4, two 6 and one was 11 years old. It is of course true that in the 7% of our recent cases in which the intussusception was reduced by barium enema alone we have had no opportunity to demonstrate the existence or absence of such mechanical lesions.

THE JOHNS HOPKINS HOSPITAL INTUSSUSCEPTION 1893-1948
RELATION OF MORTALITY
TO DURATION OF SYMPTOMS

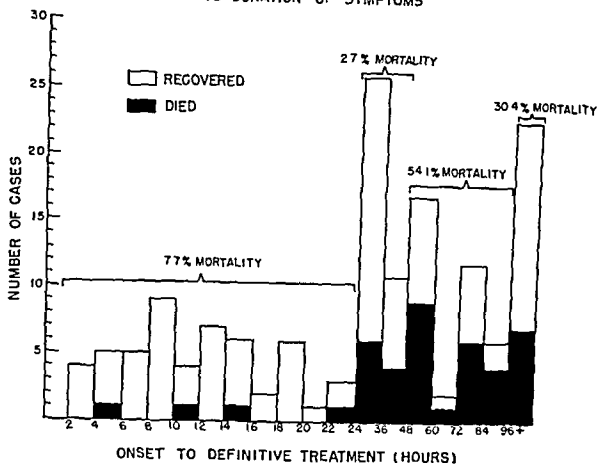


Fig 7 Intussusception—relation of mortality to duration of symptoms (1893-1948). The deaths in the group of patients seen in the first 24 hours all occurred more than 35 years ago. The mortality rises steeply in the succeeding hours and drops suddenly after 96 hours. This is due to

the appearance at this point of cases of nonstrangulating intussusception. In the absence of any current mortality it is only in the study of earlier cases that this sort of information can be elicited. (From Ravitch and McCune, *J Pediatr* 37: 1950)

nor have such lesions if they existed appeared to cause any difficulty.

In two of the five children who had polyps the polyps were excised. In one the type of operative procedure is not described and in one the involved segment was resected and that baby died (of polyposis of the entire gastro intestinal tract) and one died on the operating table before operation could be performed. The five patients in whom a Meckel's diverticulum was found all survived after resection of the diverticulum or of the segment of the bowel from which the diverticulum arose. A ten month old infant with a 30 hour old intussusception due to

a nodule of ectopic pancreatic tissue had a bowel resection and died. The enteric cyst was successfully resected with the cecum and terminal ileum. The large lymphoid focus was not excised. In general the specific lesions are rare and except in the desperately ill should be excised if encountered at operation. In older children with intussusception or in any child with a recurrent intussusception the possibility of such a lesion must be considered.

Lympho sarcoma is the occasional cause of a chronic type of nonstrangulating intussusception and the diagnosis may at times be ventured in the presence of a chronic intussus

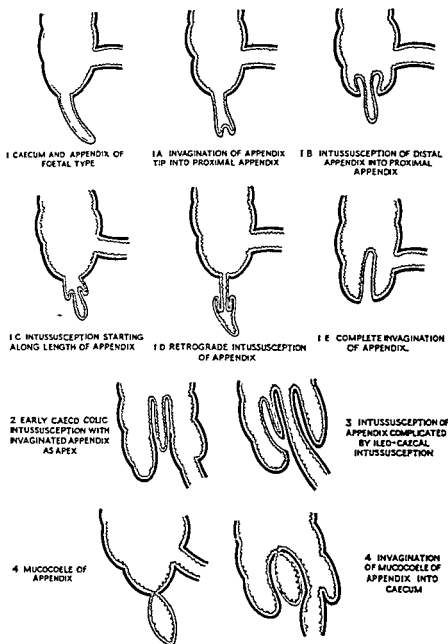


Fig 8 The Appendix in Intussusception

1 Intussusception of the appendix a The tip of the appendix forms the intussusception and is invaginated into the proximal appendix which forms the intussusciptions. The intussusception consists of only two layers—very rare b The invagination starts at the junction of the appendix and caecum. The appendix forms the intussusception the caecum the intussusciptions. This is the commonest type to which almost all appendicular intussusceptions belong c The invagination starts at some point along the length of the appendix—no recorded case d Retrograde intussusception—one recorded case e Complete invagination of appendix into caecum from progression of a b or c 2 Compound intussusception initiated

by (1) a b or c The invaginated appendix leads the intussusception 3 Ileocaecal intussusception complicated by appendicular intussusception but not led by it 4 The appendix without being turned inside out is invaginated into the caecum as in the so-called intussusception of a mucocoele of the appendix 5 (Not shown) The appendix may be drawn into the general mass of any intussusception but provided the relationship of the appendix to the caecum is not altered (see frontispiece) this does not constitute an intussusception of the appendix 6 (Not shown) The stump of an amputated appendix may be the apex of an intussusception (From Forshall 1 Intussusception of the Vermiform Appendix *Brit J Surg* 1932)

ception which resides in the cecum. At times the hypertrophied lymphoid patches in the terminal ileum which are thought to be responsible for many cases of intussusception assume such tumor-like proportions as to invite resection. Child and O'Sullivan have reported such cases and we describe one above.

The vermiform appendix may participate in or initiate an intussusception in one of a number of ways as Forshall has shown but ordinarily it is merely drawn into the space between intussusceptum and intussusciens and it is there compressed (Fig. 8).

Cross and Ware in analyzing 610 cases of intussusception found a discernible mechanical factor in only 5.4% of the cases—twenty-nine instances of Meckel's diverticulum, four of intestinal polyps, two of lymphoma of the bowel and one duplication of the terminal ileum. There is no analysis as to the ages of the children involved.

Thurston *et al.* reporting 116 cases from the St. Louis Children's Hospital found nine intussusceptions due to a Meckel's diverticulum and two more in which a Meckel's diverticulum was present but not involved in the intussusception. In two cases there were adenomata of the ileum and in one a duplication cyst of the ileum.

It will be noticed that we have made no mention of the various anatomical types of intussusceptions—ileo caeco-colic, ileo ileo-colic, ileo caecal, etc. We feel that no purpose is served by introducing these terms and that further more by fluoroscopy it is usually impossible to separate these and an operation frequently difficult. Essentially it is important to know that 95% of all intussusceptions in infants and children begin at or near the ileo caecal valve and it is with these by and large that we are concerned. Very few intussusceptions in children begin in the colon. The symptoms in these are inclined to be less acute and on the other hand in the small number of intussusceptions which begin far up in the small bowel the symptoms are fulminating and the patients usually present as cases of intestinal obstruction of uncer-

tain etiology rather than as cases of intussusception. The reason for the occurrence of intussusception in the region of the ileo-caecal valve is disputed. The disproportion between the sizes of the ileum and the cecum in infancy is greater than in later life and may perhaps more readily invite intussusception. The frequent presence of large bodies of submucous lymphoid tissue in the terminal ileum may also explain the occurrence of some intussusceptions.

No discussion of intussusception is complete without mention of the anatomical variant of the normal attachment of the cecum which goes by the name of cecum mobile. While it is not necessary to have a mobile cecum in order for intussusception to occur it is obvious that the free progression of an intussusception around the colon and down into the rectum as frequently occurs would be impossible were the cecum to be firmly fixed. It is the relative mobility of the cecum in many infants which permits the extensive progression of so many intussusceptions.

BIBLIOGRAPHY

- ARKEREN Y and Petterson G. Intestinal intussusception during the neonatal period. *Acta chir scandinav.* 107:50-552, 1951.
- Bolling R W. Acute intussusception in infants. *Ann Surg.* 78:319-356, 1923.
- Close H C. Acute intussusception in children. *Cuy's Hosp Rep.* 81:136-113, 1931.
- Court S D M and Jones J D T. The management of intussusception in childhood. *Med Illus* 9:63-68, 1935.
- Dennison W M. Acute intussusception in infancy and childhood. *Chasgow M J.* 29:71-80, 1918.
- Dennison W M. Personal communication, 1937.
- Fitzwilliams B C L. The pathology and aetiology of intussusception from the study of 1,000 cases. *Lancet* 1:628-633, 1908.
- Forshall I. Intussusception of the vermiform appendix with a report of 7 cases in children. *Brit J Surg.* 40:303-312, 1953.
- Fox I F. Intussusception—Surgical treatment. *S Clin North America* 36:1501-1509, 1946.
- Coldman L and Elmore R. Spontaneous reduction of acute intussusception in children. *Am J Surg.* 40:259-263, 1910.

- Gross R E and Ware P F Intussusception in childhood experiences from 610 cases *New Eng land J Med* 239 645 652 1948
- Harkins H N Intussusception due to invaginated Meckel's diverticulum *Ann Surg* 98 1070 1095 1933
- Hellmer H Intussusception in children diagnosis and therapy with barium enema *Acta radiol Suppl* 65 1948 pp 1 120
- Hipsley P L Acute intussusception *Brit M J* 2 717 721 1935
- Hogg B M and Donovan E J Acute intussusception in infants and children *Ann Surg* 124 262 267 1946
- Holowach J Thurston D L and McCoy E E Intussusception due to Meckel's diverticulum *A M A Arch Surg* 67 699 707 1953
- Illingworth C F W and Dick B M *A Text Book of Surgical Pathology* 5th Ed London Church ill 1947
- Jeffrey F W Intussusception in newborn *Canad M A J* 54 271 272 1946
- Jones J D T Treatment of irreducible intussusception *Brit M J* 2 1304 1306 1953
- Kahle H R Intussusception in children under two years of age *Surgery* 29 182 195 1951
- Kahle H R and Thompson C T Diagnostic and therapeutic considerations of intussusception *Surg Gynec & Obst* 97 693 701 1953
- Ladd W E and Gross R E Intussusception in infancy and childhood *Arch Surg* 29 365 384 1934
- Ladd W E and Gross R E *Abdominal Surgery of Infancy and Childhood* Philadelphia Saunders 1941
- Leichtenstern O Intussusception invagination and darmenschiebung in Ziemssen's *Cyclopaedia of the Practice of Medicine* 7 610 621 1877
- Ling J T Intussusception in infants and children *Radiology* 62 505 513 1954
- MacFarlane D A and Thomas L P Early recurrent acute intussusception in children *Brit M J* 1 559 560 1951
- MacMahon Brian Data on the etiology of acute intussusception in childhood *Am J Human Genetics* 7 430 437 1955
- Nordentoft J M The value of the barium enema in the diagnosis and treatment of intussusception in children *Acta radiol* 24 484-488 1913
- Nordentoft J M The value of the barium enema in the diagnosis and treatment of intussusception in children illustrated by about 500 Danish cases *Acta radiol Suppl* 51 1943
- O Sullivan W D and Child C G III Ileocecal intussusception caused by lymphoid hyperplasia *J Pediat* 38 320 324 1951
- Packard G B The treatment of intussusception in infancy and childhood *Pediatrics* 15 291 297 1955
- Packard G B and Allen R P Results in the treatment of intussusception in infants and children *Surgery* 41 567 575 1957
- Parkkulainen K V A cause of intestinal atresia *Surgery* 44 1106 1111 1958
- Perrin W S and Lindsay E C Intussusception a monograph based on four hundred cases *Brit J Surg* 9 46-71 1921
- Rachelson M H Jernigan J P and Jackson W F Intussusception in newborn infant *J Pediat*, 47 87 94 1955
- Ravitch M M Polypoid adenomatosis of the entire gastro-intestinal tract *Ann Surg* 128 283 298 Aug 1948
- Ravitch M M and McCune R M Jr Intussusception in infants and children *J Pediat* 37 153 173 1950
- Santulli T V and Ferrer J M Jr Intussusception — an appraisal of present treatment *Ann Surg* 143 8 17 1956
- Snyder W H Jr Kraus A R and Chaffin L Intussusception in infants and children a report of 143 consecutive cases *Ann Surg* 130 200 210 1919
- Spence J and Court D Acute intussusception in childhood *Brit M J* 2 920 1950
- Thatcher D S Intussusception in infants and children *Ann Surg* 140 180 184 1954
- Thurston D L Holowach J and McCoy F E Acute intussusception analysis of 116 cases at St Louis Children's Hospital *A M A Arch Surg* 67 68 79 1953
- Treves F *Intestinal Obstruction* London Cassell & Co 1901
- Wakeley C P G and Atkinson F R B Acute intussusception in childhood *Brit J Child Dis* 35 241 250 1938
- Weta *The Acute Abdomen in Rhyme* London Lewis 1955

ERRORS IN THE DIAGNOSIS OF INTUSSUSCEPTION

In periodically reviewing our experience with intussusception we were struck some years ago by the fact that five deaths occurred in our experience between 1939 and 1946 all of these in patients treated primarily by operation. What was most disconcerting was the discovery that in each of these five instances a serious delay had occurred in the initiation of definitive treatment. In each instance the delay was caused by failure to diagnose the intussusception upon the patient's first visit to the hospital after the onset of the condition. In one child it is true intussusception was only an incident in the course of an already established fatal disease but the other four children should not have died had the diagnosis been made promptly. This experience led us to review the histories of the children in whom intussusception was improperly diagnosed at The Johns Hopkins Hospital in the period 1930 to 1951 in order to illuminate if possible the more common diagnostic pitfalls. We now record a further review to 1958 and combine the two groups.

By and large intussusception is a readily diagnosed disease with an easily recognized symptom pattern. It is well to note that in many children the symptoms and signs of intussusception supervene during a mild illness such as an upper respiratory infection or a bout of non-specific diarrhoea. Those who feel that the presence of enlarged submucosal lymphoid masses predisposes to intussusception see a causal relation

ship here. In any event, the possibility of intussusception may be thought of in a child who seems much sicker than his obvious upper respiratory infection or history of previous mild diarrhoea would suggest. A few patients have strong and clear histories of previous similar attacks from which they recovered spontaneously. Such a history should sharpen suspicion not allay it.

Diarrhoea during the period of intussusception occurred in 15 or 75% of our entire series of 199 cases and 13 of these 15 patients were under one year of age. This is of extreme importance for there is an understandable tendency to assume that in the presence of intussusception there must be complete intestinal obstruction. Of these 15 children the condition was actually mistakenly diagnosed in seven as dysentery and three of them subsequently died as the result of the delay. In the period 1930-1958 121 children with intussusception were treated at The Johns Hopkins Hospital. In 23 of these there was an initial error in diagnosis which affected the treatment and eight of these 19 children died all before 1946. With these brief facts and bearing in mind the pattern of history and physical examination in ordinary cases of intussusception as discussed in detail in Chapter II we may proceed to an analysis of the cases in which there was a diagnostic error with a significant ensuing delay. A study of this kind obtains its chief value from an examination of the clinical characteristics of the cases

reviewed and does not lend itself to statistical tabulation so that it seems most profitable to discuss the cases in groups using the individual cases for illustration

Our errors in making the diagnosis have fallen into several categories. One instance was that of a patient who showed all or most of the signs of an intussusception which was not recognized because of the ignorance of the examining physician. In a second group the diagnosis was missed because of the rather long duration of the symptoms and the relative well being of the child. There were five such cases in all of them the diagnosis was not entertained because the history went back for periods varying from a week to as much as 40 days during which the general condition of each child remained good. Ultimately in each instance admission to the hospital was precipitated by the worsening condition of the child. One must ever keep in mind the occasional occurrence of chronic non strangulating incompletely obstructing intussusception.

One of the commonest errors was in making the diagnosis of dysentery based upon fever vomiting bloody stools and abdominal pain. In this series there were seven patients in whom the erroneous diagnosis of dysentery was made. When one considers how common dysentery is and how variable its manifestations it is small wonder this error was made. One can only suggest that intussusception must be kept in mind.

In two cases there was sufficient spasm, rigidity and tenderness to simulate an acute abdominal condition requiring surgery. In one a diagnosis of appendicitis seemed unequivocal with tenderness and spasm in the right lower quadrant, no palpable mass and no bloody stool. At operation the appendix was found to be normal and intussusception was found. In the other case there was first tenderness in the right upper quadrant then considerable rigidity and consequently the possibility of appendicitis, sickle cell crisis or other cause of abdominal pain and spasm was entertained. Eventually after administration of secobarbital sodium a mass was

felt and the diagnosis made by barium enema. It is worth remembering therefore that abdominal spasm may be an important feature of these cases and may prevent early palpation of the mass.

Palpation of the intussuscepted bowel should not be considered a *sine qua non* for the diagnosis. In the group of 23 cases of delayed diagnosis 1930-1951 there were nine in which no mass was ever felt by abdominal palpation or by rectal palpation and ten cases in which there was a variable delay before palpation of a mass ultimately established the diagnosis. In one case a palpable liver was repeatedly mentioned. This may well have been the intussusception. In two cases the mass was felt but thought to be a neoplasm or a cyst. In some cases the mass was undoubtedly under the right costal margin and therefore not palpable. In others it may have been obscured by distention and in still others by tenderness and spasm. In 7 of the 23 cases the intussusception involved the ileum only. In 4 of these no mass was ever felt.

The age of the patient was misleading to the pediatrician in several instances. Of the total group of 23 patients whose condition was initially misdiagnosed there were 8 patients over a year old including 7 over two years and there was one who was 2 weeks old. Of the 199 cases analyzed almost 90% were under 2 years old and 57% were 4-11 months of age. In this group of 23 children 7 or nearly a third were over 2 years old. One tends to forget the possibility of intussusception in the older age groups as well as in newborn infants.

Blood in the stools or currant jelly stools is another classic sign of intussusception. That it may not appear in an appreciable number of cases is evident since it did not appear at all in 10 of our 19 undiagnosed cases. Indeed in several cases the stools were normal or nearly so and in some others there were repeated watery stools. In some cases there was occult blood in the stools and in others it was found only by rectal examination.

In two cases and possibly a third the issue

was beclouded because the patients were already in the hospital with another disease. An additional case of this kind was seen recently in an infant admitted to another hospital with severe and flagrant varicella. It was thought by some observers that all of the symptoms could be explained by intestinal involvement in an enanthem and accurate diagnosis was delayed for several hours on that account.

Occasionally a blatantly typical case is misdiagnosed as in the following instance.

P. G. a ten month old girl was seen in the dispensary with a temperature of 101.8 and a history of fever, vomiting and constipation for over 24 hours. An enema the night before had returned bright red blood. The abdomen was distended and there were no fecal masses, no tenderness, masses or spasms. Enema return in the dispensary was practically clear except that the water was tinged with light pink. Diagnosis was otitis media, chronic constipation (?) intussusception. The child was sent home to return the next day. However the error was detected that night by the dispensary chief in a review of the day's histories and the baby was found and brought in 12 hours after the first dispensary visit. The child was now flaccid and almost completely unresponsive. A diagnostic barium enema filled the colon. Roentgenograms showed numerous loops and fluid levels and upon operation a short intussusception was found just above the ileocecal valve. It was not gangrenous but was irreducible. Resection and anastomosis were performed. The child's temperature rose to 101.4 C (104.5 F). She had convulsions for six hours and died. The specimen showed the intussusception to have been due to a nodule of aberrant pancreatic tissue.

This child had vomiting, constipation and blood in the bowel when first seen and consideration of intussusception should have been obligatory regardless of the absence of a mass which was all that was lacking. If the mere thought of intussusception is entertained a barium enema should be administered and only if the small bowel fills readily and there are no fluid levels or distended loops may the possibility be dismissed. It is true that in this instance the intussusception was entirely in the small bowel which makes for more difficult diagnosis and higher mortality. However films

of the barium enema showed dilated loops and demonstrated the existence of a mechanical intestinal obstruction, a mandatory indication for operation in itself.

There was one other case of essentially inexcusable diagnostic inaccuracy which fortunately resulted in recovery. While everyone may at times fail to see the obvious and high index of suspicion in regard to intussusception and a sense of urgency in the presence of the possibility of intussusception should reduce the number of diagnostic errors.

It is possible in some of the cases to see how the examiners were misled.

In six cases the duration of the illness was so long and the children in such good condition that the correct diagnosis was not entertained until late. These cases were of very different types.

The first case was that of a six year old child with a two year history of anemia, abdominal pain, anorexia and watery stools with occasional vomiting. She had frequent attacks of abdominal pain when a mass was visible in the abdomen. Even though these attacks occurred during a hospital admission intussusception seems not to have been considered. Laparotomy was finally undertaken and two separate intussusceptions were found with polyps in each small bowel area.

This child had peculiar pigmentation (Hutchinson-Jeghers-McKusick spots) on the lips, the significance of which as indicating diffuse intestinal polyposis was not then realized. The chronicity of her complaint and the extensive blood loss due to the polyps had led to diagnosis of Meckel's diverticulum, ulcerative colitis, etc. In actuality repeated bouts of intussusception are a regular feature of the several syndromes associated with multiple small intestinal polyps.

Another patient celebrated in the annals of the Harriet Lane Home was an eight month old girl whose initial dispensary visit was on the 11th day of illness. This had begun with abdominal pain and a normal evacuation followed after five hours by the passage of blood. She vomited every day had fever every day and had one or two normal stools every day until the day of her first visit when she had a bloody, watery stool. Examination showed

dehydration a palpable liver a fluid brown stool and blood in the rectum. She was thought to have dysentery and was followed thereafter for 40 days during which she made 25 dispensary visits. Some times she had diarrhoea sometimes not sometimes she vomited sometimes not sometimes she passed blood sometimes not. She never failed to have a stool but often had bouts of pain. The liver was usually palpable.

She was finally admitted to the hospital where after three days a barium enema was given as part of the diagnostic study and was interpreted as normal. The next day a mass was finally felt. Barium enema reduced a typical intussusception from the transverse colon to the ileocecal valve and reduction was completed at operation. The child had no trouble thereafter. Review of the first roentgenograms which had been read as normal actually showed a typical chronic intussusception (Fig. 9).

In this instance despite innumerable bloody stools bouts of pain and vomiting the possibility of intussusception was ignored because of the long history and the absence of obstruction in an eight month old infant who was obviously not desperately ill.

The next child in the group with chronic intussusception was a one year old girl with vomiting and constipation of one week's duration and with a history of flecks of blood in an enema and repeated bouts of periodic abdominal cramps. The abdomen was distended a roentgenogram showed dilated loops and intestinal obstruction was suspected but because her condition seemed exceptionally good she was sent home to return the next day! She was then distended there was tenderness and spasm in the right lower quadrant and the suggestion of a mass. She was thought to have a low intestinal obstruction. Barium enema showed an intussusception in the right lower quadrant for which operation was undertaken. The intussusception was reduced.

In this instance the picture was largely that of intestinal obstruction for which admission and operation should have been advised in any case.

The fourth case of delayed diagnosis in a child with a long history was that of a 2½ year old girl who had a ten day history of illness. This had begun with sudden severe cramps which persisted at frequent intervals. She vomited after almost

every meal but she had normal stools without any blood for the two days preceding admission. She was thin dehydrated and crying with frequent spasms of abdominal pain. There was much audible peristalsis. Hard dry feces lay in the rectum. There was tenderness and muscle spasm in the right upper quadrant and a poorly defined tender mass. She was observed for 12 hours for () lead poisoning (r) appendiceal abscess until a diagnostic barium enema showed an intussusception at the hepatic flexure. Operative reduction was successful.

There seems little justification for the delay in operation although the absence of bleeding and distention are extenuating factors and although the mass must have been partly concealed by the liver and the right costal margin.

The fifth child in this group was a six month old boy with a three month history of cramps and vomiting occurring in episodes. He had daily stools and never passed blood. Three days before admission a tubular non tender mass in the left upper quadrant was felt and taken to be an enteric cyst. Upon operation this mass proved to be an intussusception at the splenic flexure. When it was reduced a mass at the ileocecal junction was discovered and resected and turned out to be a small enteric cyst which had led the intussusception.

The sixth case in this group is similar to the fifth. A five month old boy was seen by his physician 24 hours after onset of vomiting and constipation and having failed to respond to a change in formula was seen at the hospital after another 18 hours. He did not appear ill was only slightly dehydrated afebrile. A firm round movable mass was felt in the right mid abdomen. He was considered for six hours to have an abdominal neoplasm before a barium enema was finally administered and the intussusception in the mid transverse colon encountered and reduced.

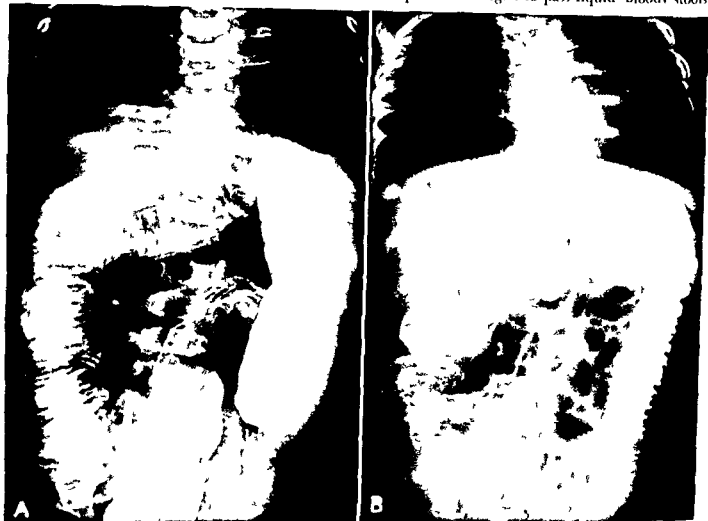
The most interesting feature common to all these children is that despite the fact that they had long standing intussusceptions from one or two days to others varying in duration from ten days to a month or more all survived and none had gangrenous bowel. This is inherent in the nature of chronic intussusception. A moment's reflection will show that precisely those children will have chronic intussusception of long standing whose intussusceptions do not become

gangrenous and in whom neither the intestinal canal nor its vascular supply becomes completely obstructed. One should not insist upon feeling a mass before resorting to barium enema. The mere fact of a long history in a child who is still in tolerably good general condition does not exclude intussusception and the child may continue to pass stools daily. By the same token in these cases bleeding into the bowel may be

inconspicuous or absent.

A very small group is represented by two children who were already in the hospital and seriously ill when intussusception supervened.

An 18 month old boy was in the hospital dying of malnutrition as a result of diffuse polypsis of the entire intestinal tract. This had resulted in almost constant diarrhoea. In the ward a long time after admission he spent a bad night with abdominal pain and began to pass liquid bloody stools.



Chronic Intussusception

Fig 9 C B Female 8 months old. This child was first brought to the hospital 14 days after a bout of abdominal pain followed by passage of bright red blood. She had vomited daily, had fever, lost appetite, but had continued to have one to two bowel movements a day, some watery and with blood. She had lost 3 pounds. She was seen on 23 separate visits to the hospital. On the first visit it was noticed that she had what was thought to be a palpable liver and upper abdominal fullness. Her visits were usually occasioned by fever, vomiting, diarrhoea and bloody flecks in the stools. She was finally admitted to the hospital 33 days after the first visit for this complaint. On

only one or two occasions in her dispensary visits had no mass been felt. She had appeared a puny child and had generally been thought to have hepatomegaly. Her admission diagnosis was dysentery. She had lost weight and had never stopped vomiting. On admission she was described as having a soft liver with rounded edge two or three fingers breadth below the costal margin. Three days after admission the mass was identified as being sausage shaped and conceivably an intussusception, and a diagnostic barium enema was requested of the Radiology Department. No surgical consultation was requested. The

(Continued on next page)



Fig 9 (Cont)

mass apparently disappeared just before the roentgenogram was taken and the characteristic findings seen in this film were not appreciated. The following day the mass was palpated once more and the diagnosis confirmed on surgical consultation. Barium enema reduction demonstrated a typical intussusception at the splenic flexure which was readily reduced to the cecum beyond which it could not be moved. Through a small McBurney incision the cecum was delivered and less than a centimeter of bowel appeared to be still intussuscepted. This was readily reduced. There remained so much edema at this point that the bowel was opened found to be normal but for the edema and closed. The appendix was removed; the child left the hospital well eight days later. The coiled spring appearance is typical of a chronic intussusception. The edema of the non-strangulated bowel produces the large ring like filling defects in the barium which enters between the intussusceptum and the intussusciptens. The absence of complete intestinal obstruction does not rule out the possibility of intussusception. The commonest erroneous

diagnosis leading to delay in the treatment of intussusception is dysentery.

- A This was a diagnostic study undertaken when the diagnosis of intussusception was not very seriously entertained. Although barium reaches the right lower quadrant the characteristic coiled spring appearance is seen from the splenic flexure around to the right lower quadrant.
- B With expulsion of some of the barium what is presumably cecum seems empty and the coiled spring chronic non-strangulating non-obstructive intussusception is seen in the transverse colon and hepatic flexure.
- C Enlargement of B to show the coiled spring more clearly.

It is probable that the intussusception moved back and forth for a month or more almost reducing entirely at times passing far around the colon at others. (From Ravitch *Am J Dis Child* 81 1952)



Intussusception Superimposed on Other Disease

Fig. 10 C B Male fifteen months old (B C H). This child had been ill at home for a week with an upper respiratory infection and the obvious manifestations of chicken pox. During this period he had vomited several times. The day before admission he began once more to vomit and became distended. He had had abdominal pain from time to time during this entire week. At the time of admission he had the flagrant rash of chicken pox. In spite of the history of abdominal pain and vomiting it was assumed that the distention was due to involvement of the

bowel with the exanthem of varicella and it was 24 hours before a barium enema was undertaken.

A The plain film shows numerous dilated loops of small bowel and no loop identifiable as colon.

B The colon filled readily without demonstrating an intussusception but a peculiar shadow was seen in the small bowel (just opposite the bend in the gastric tube in the film) when the rectal catheter was withdrawn and the patient allowed to evacuate the excess barium.

(Continue on next page)

After 24 hours a mass was felt in the right upper quadrant. The mass developed rapidly. It was explored and found to be an ileocolic intussusception. The child died 24 hours after operation. At autopsy the entire bowel from caecum to anus was found to be studded with these polyps.

A nine month old girl was admitted with a two week history of green diarrhoeal stools, blood in the stools, fever, cough and persistent vomiting. There was right upper lobe pneumonia. The child was very dehydrated, the eyes and the fontanelles

were sunken. The abdomen was scaphoid. The temperature was 103.6 C (105.1 F). The abdomen became tympanic and distended almost at once and she began to pass gross blood in the stools with much mucus. After 72 hours she was markedly distended and sicker despite clearing of the pneumonia. Barium enema was normal but she was having repeated currant jelly stools. Upon operation a necrotic ileocolic intussusception was found and resected, death eventuating.

In both these instances intussusception devel-



Fig. 10 (Cont.)

C The colon was seen to be filled completely as well as a few inches of terminal ileum. Proximal to this was the sausage shaped double shadow of an unreduced intussusception. Operation was immediately undertaken. An irreducible ileo ileal intussusception was resected and primary anastomosis performed.

The child recovered without incident. Such radiologic demonstration of an intussusception in the ileum is rare. The plain films showing dilated small bowel loops and no gas in the colon should have led to operation for intestinal obstruction.

opened in a child already seriously ill and in the hospital and the diagnosis was delayed because the child was already in the hospital on another account. Members of the staff were slow to appreciate the significance of the change in symptomatology. It is possible of course that the second case was one of intussusception from the first although there appears to have been a sharp and sudden change in the clinical picture.

A recent case involves another instance of pre-existent and coinciding disease seen in another hospital.

A 14 month old boy was admitted to the hospital with obvious chicken pox and abdominal distention. Seven days before he awakened from a nap like a wet dish rag and vomited. He had a normal stool that night but slept poorly. For the next three days he ate poorly, vomited often and slept a good deal and after three days without a stool passed a reddish watery movement. He began to improve eating better, vomiting less when he developed a rash and abdominal distention. The rash was characteristic of chicken pox; there was a soft distention of the abdomen and a watery mahogany colored stool.

Intussusception was at once thought of but the obvious varicella and the prolonged history in a child still in relatively good condition led to the suggestion that the problem was one of paralytic ileus due to the presence of intestinal enanthems. It was 24 hours before a barium enema revealed not only the distended loops of bowel which had been attributed to paralytic ileus but a characteristic filling defect in the terminal ileum (Fig. 10).

At operation a gangrenous intussusception of the terminal ileum was resected. The specimen does not show any unusual features. The child made a rapid recovery.

In this instance the existence of florid chicken pox led to the dismissal of a fairly characteristic history of intussusception and the erection of a labored clinical structure attributing the distention to paralytic ileus and visceral chicken pox and the bloody stools to ulcerated enanthems. Barium enema fortunately outlined an intussusception in the ileum—a rare event.

The largest group and the most deceptive consists of the babies who were first thought to have dysentery and finally were found to have intussusception. There were eight of these children. When the variable character of early dysentery in infants and children is remembered this error does not seem so remarkable although again it is preferable to conduct barium enema studies on the mere suspicion of the possibility of an intussusception.

A ten month old baby was admitted to the dispensary with a temperature of 103.1 F after 24 hours of vomiting while the stools were normal; the throat was red, the eyes sunken and the child was restless. She was treated for dysentery in the pre-diarrhoeal

stage. The next day with a temperature of 106.6°F she was admitted to the hospital. She was very well nourished to the point of obesity and seemed fairly well. There was tenderness and resistance in the right upper quadrant. She was thought to have a paralytic ileus of unknown origin. Roentgenograms showed dilated loops. Two days after admission laparotomy showed a gangrenous intussusception which was resected. The child died soon after.

In this instance obesity of the child interfered with abdominal palpation and with accurate assessment of the condition. There appeared from the record to be a constant search for real abdominal rigidity in a ten month old infant. It is well known that in young infants there may be little or no abdominal resistance in acute abdominal lesions. The presence of constipation, distention and vomiting were not properly evaluated.

The next child also died. He was a six month old infant with a 18 hour history of bloody stools, vomiting and crampy abdominal pain. He was in shock, bleeding from the rectum and severely dehydrated. Rectal examination showed bloody mucus. It was discovered that the child had been offered egg for the first time on the day of onset and therefore time was taken to test his allergy to egg albumin which proved minimal. Roentgenograms showed dilated loops and after several hours operation was undertaken. At operation an ileocolic intussusception was discovered and reduced. His temperature rose to 116°C (106.8°F) and he died, perhaps as a result of scanty supportive treatment, having received only a little dextrose before the operation and only 100 cc of blood after the operation.

In this instance a delay of a few hours was occasioned by neglect of the obvious indications of intussusception with a clear clinical picture except absence of a mass. The intussusception was ileocolic. The time which was wasted could have been employed in vigorous transfusion therapy.

The third child mistakenly thought to have dysentery was eight months old. He came to the hospital shortly after having passed four watery yellow stools and having vomited several times. He was obviously acutely ill and was sent home as having dysentery. Next day he appeared to be having cramps and had a bloody mucous stool. There was now a mass in the

right upper quadrant. Barium enema reduced a typical intussusception to the right colon whence reduction was completed at operation.

The fourth infant in the dysentery group came to the dispensary after 18 hours of vomiting and no stool. He was thought to have an acute nutritional disturbance. He was given fluids intravenously and feedings were ordered withheld. Several hours later he was brought back to the hospital with colicky pain and a right upper quadrant mass. There was blood on the finger after rectal examination. Barium enema reduced the intussusception to the cecum and operation completed the reduction.

In this case vomiting and the fact that the child had been one day without a stool were all there was to arouse suspicion but a barium enema might have been advised because of the question of intestinal obstruction.

The fifth child in this group, an eight year old boy, had a ten hour history of severe cramps with vomiting and several watery stools with mucus and blood. The abdomen was rounded and slightly distended. Rectal examination yielded a liquid stool with blood, mucus and white blood cells. The diagnosis upon admission was dysentery but after several hours a barium enema was done which showed an intussusception in the descending colon which was readily reduced by hydrostatic pressure.

The sixth child in this group was a seven month old girl with a two week history of vomiting, having ten to twelve diarrhoeal stools a day, fever and moribund. Blood appeared in the stools the day before her first visit and on that day she had only three to four stools. The temperature was 101.1°F. She was irritable, toxic and slightly dehydrated and the ear drums were red and bulging. The liver was felt two centimeters below the costal margin. A myringotomy was done and she was sent home. The next day she was vomiting and had a loose purulent stool, a tender abdomen and a rectal prolapse. She was admitted and the following day a barium enema showed a normal colon but distention increased and stools ceased altogether. At operation an ileocolic intussusception was reduced. The child seemed to be recovering when colon bacillus meningitis developed and she died.

Her cramps, vomiting and tenderness had been ignored and it is possible that the liver was the intussusception. Intussusceptions which do not enter the colon are radiologically and

clinically difficult to diagnose. Cramp like pain, vomiting and distention should have suggested mechanical intestinal obstruction. It is infinitely more costly to delay operation for mechanical intestinal obstruction until diagnosis is absolutely certain than to operate occasionally for what proves not to have been an obstruction.

The seventh child mistakenly thought to have dysentery was a five month old girl first seen at the hospital a few hours after the sudden onset of vomiting and diarrhoea. Blood appeared in the stool after her first hospital visit. Finally admitted 48 hours later she was prostrated, weak, lethargic, dehydrated. A mass was felt in the left lower quadrant and reduced by barium enema and she recovered. Her case is described in detail in Chapter V under Complications of Barium Enema Treatment.

The eighth child in this group was an eight month old boy whose illness began with a sudden bloody diarrhoea. Seen soon after he was passing bloody watery yellow stools and although exhibiting periodic cramps and vomiting repeatedly was sent home on sugar water. On his return the next day he was profoundly prostrated, severely dehydrated and acidotic. A mass was easily palpable in the left lower quadrant. The intussusception was reduced by barium enema from the sigmoid to the ascending colon and further reduction completed at operation.

A ninth child with diarrhoea six weeks of age had been followed at the Harriet Lane Home and Dispensary for most of its brief life with constant diarrhoea and occasional bleeding.

The child was admitted to the Baltimore City Hospital moribund and with a profound marasmus. Despite the continuing diarrhoea because there was now blood in the stools a barium enema was advised. The plain film showed numerous distended loops of what appeared to be small bowel with no recognizable loops of colon. A barium enema was undertaken and no intussusception was recognized. A subsequent review of the films (Fig. 11) showed an obvious meniscus in the ascending colon with the suggestion of a compound intussusception. The final films showed incomplete filling of the colon although there was a little dribble of barium into the ileum. For this reason operation was insisted upon. The intussusception was found to have been completely reduced by the barium enema, only a cyanotic annular ring in the ileum some inches proximal to the ileo cecal valve indicating the previous

presence of the intussusception.

The child marantic and moribund on admission from its long diarrhoea continued in its previous state for two days and died. Autopsy showed an extensive and profuse enteritis.

In one child a girl of 29 months an attempt was made to establish the diagnosis of meningitis.

She was admitted to the hospital 18 hours after the onset of vomiting and cramps. She was markedly distended and intestinal pattern and peristalsis were conspicuous nevertheless in the absence of a mass or of blood in the rectum her extreme listlessness and drowsiness suggested a central nervous system disorder such as encephalitis or meningitis. Lumbar puncture was negative. After five hours a barium enema was performed and showed multiple fluid levels, a stepladder pattern and a typical intussusception at mid transverse colon reduced to the ileum. At operation the ileoileal component was reduced manually. The child remained stuporous for days before recovering and it is not impossible that we were dealing with intussusception supervening in a child with encephalitis.

At least three children suffered a delay in diagnosis because of a compound error; it was or should have been evident that some other form of mechanical intestinal obstruction might be present or some other acute abdominal process yet the child was not admitted to the hospital for immediate operative treatment.

One child of six years was seen after 48 hours of periumbilical pain and vomiting with no stool in the second 24 hours. The liver was thought to be palpable. An enema was ineffectual but the child was sent home. He was brought back the next day markedly ill, dehydrated and distended with numerous dilated intestinal loops. It was thought that he might have peritonitis and ileus but operation showed a large ileocecal intussusception which was resected. Death followed soon after operation.

A four year old boy with a similar history was more fortunate. He had a two day history of abdominal cramps was sent home and returned in 21 hours having vomited several times. There was a little spasm in the right upper quadrant and active peristalsis. He was sent home again and returned the next day with cramps, distention and right upper quadrant tenderness and spasm. With the child under sedation with secobarbital sodium a typical intussusception was felt. Barium enema reduced it.



Intussusception Misdiagnosed Dysentery

Fig 11. D. L. Female six weeks (B. C. H.). This baby was admitted to the hospital moribund with a history of diarrhoea for most of its brief life and occasional bleeding. Despite the continuing diarrhoea because there was blood in the stools a barium enema was advised.

A. The plum film shows numerous distended loops. The colon is not recognizable.

B. The observers did not note any intussusception under the fluoroscope but this film shows an obvious meniscus in the ascending colon and suggests also that there may have been a compound intussusception with the colocolic portion in the transverse colon in process of being reduced at this point.

(Continued on next page)

to the cecum and operation completed the reduction.

In this instance the boy was twice sent home despite rightsided abdominal tenderness and a history of cramps for which admission and operation should have been advised from the first.

By contrast with these cases there is the following case history —

A 3½ year old white boy had a twelve hour history of generalized abdominal pain, nausea and vomiting with no stool in that time. There were tenderness and rigidity in the right lower quadrant. Operation for appendicitis was promptly undertaken. An intussusception was found to have passed into the

ascending colon and reduction and cure were readily accomplished.

Intussusception had not been suspected and no barium enema was performed but operation was undertaken without delay and the result was good.

There was one fatal case in which we see no opportunity for the diagnosis to have been made —

A two week old infant with diarrhoea had been having up to seven or eight stools a day since the second or third day of life. There had been no vomiting and no blood in the stool. He had taken

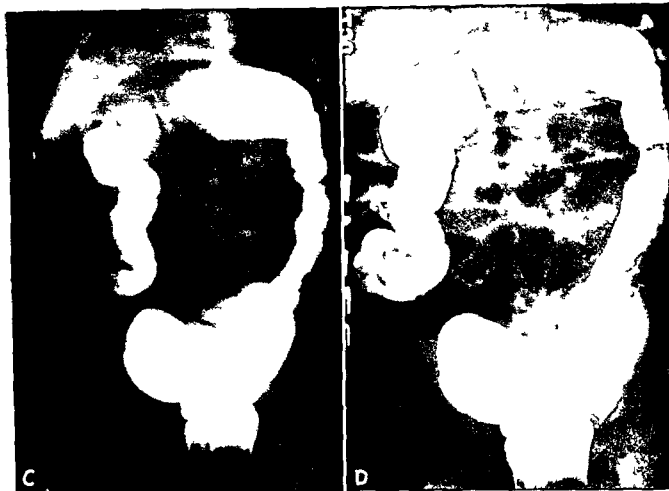


Fig. 11 (Cont)

C & D The colon appeared to fill incompletely and although a little barium passed into the ileum there was a failure of the ileum to fill freely. On this account after a review of the films several hours later operation was insisted upon. The intussusception was found to have been completely reduced and only a cyanotic annular ring in the ileum some inches prox-

imal to the ileo cecal valve indicated that intussusception had been present.

The child marantic and moribund on admission from its long diarrhoea continued in its previous state for two days and died. Autopsy showed an extensive and diffuse enteritis.

feedings until four days preceding admission. The abdomen was soft. There was no vomiting and no distention. At autopsy a gangrenous intussusception in the midileum was found.

It is worthy of note that in 7 of the 23 cases of mis-diagnosed intussusception the intussusceptions were definitely ileoileal and had not yet involved the colon. This being a disproportionately high figure in view of the low incidence of such intussusceptions in the entire series it must be assumed that there is a direct connection between the occurrence of ileoileal intussusception the difficulty in diagnosis and

the high mortality. There have been 16 deaths in the 121 cases of intussusception since 1930 and in 8 of these the intussusceptions were ileoileal. The incidence of intussusceptions beginning high in the small bowel was 10% or less in the entire series further emphasizing the special character of such intussusceptions.

Errors in diagnosis of intussusception occurred in at least 23 cases in our hospital since 1930 these errors were associated in 22 cases with significant delay in treatment. In the 23rd case appendicitis was thought to be present and upon operation the intussusception was found and re-

lived. Errors in diagnosis were based on a number of misconceptions. In some cases a history of days or weeks of pain vomiting constipation etc. with relative well being was not recognized as characteristic of chronic non strangulating intussusception. In 8 cases the passage of feces even to the point of diarrhoeal stools was enough to lead the examiners astray with the suspicion of dysentery. In several cases intestinal obstruction of uncertain type was thought to exist but operation was inexplicably not immediately undertaken. On the one hand, in many of the cases too much stress was laid on failure to feel a mass while on the other hand an enlarged liver was palpated in several cases and insufficient weight was attached to a finding of slight abdominal tenderness or resistance. In some cases the absence of currant jelly stools apparently encouraged delay but in others pink enema returns or a history of blood in the stools failed to alarm the observers.

In three cases the children had established diagnoses of other disease pneumonia diffuse intestinal polyposis varicella and this delayed the recognition of a supervening intussusception.

If we are to lose no children from intussusception early accurate diagnosis is required. This calls for a high measure of suspicion and a ready resort to barium enema and plain roentgenograms of the abdomen in doubtful cases.

A barium enema which runs into the distal ileum rules out the ordinary type of intussusception at the ileocecal valve but does not rule out one higher in the ileum. The latter will usually show distended gas filled loops in the roentgenogram. Mechanical intestinal obstruction from any cause requires early relief by operation. Alertness to advise early operation for suspected intestinal obstruction will benefit the patients with obstruction far more than it will harm the occasional patients who will prove to have been unobstructed. Had this practice been followed in the cases reported above it might have saved a number of children in whom intussusception produced a picture of intestinal obstruction the importance of which was minimized.

The last death in this group occurred more than 12 years ago evidence of a trend towards more accurate diagnosis and more vigorous early treatment.

BIBLIOGRAPHY

- Jeghers H. McKusick V. A. and Katz H. K. Generalized intestinal polyposis and melanin spots of oral mucosa lips and digits. *New England J Med* 241 993 1005 1919.
- Ravitch Mark M. Polypoid adenomatosis of the entire gastro-intestinal tract. *Ann Surg* 128 283 298 1918.
- Ravitch Mark M. Consideration of errors in the diagnosis of intussusception. *A M A Im J Dis Child* 84 17 26 1952.

PATHOLOGICAL AND EXPERIMENTAL STUDIES IN INTUSSUSCEPTION

Despite widespread interest in the clinical aspects of intussusception there have been few experimental studies of the problem. In 1893 Nicholas Senn found that manually produced intussusceptions in cats would reduce spontaneously if not fixed by sutures. He reduced experimental intussusception by insufflation of hydrogen gas and considered this the preferred method of therapy in patients. Senn's studies are perhaps the only ones before our own dealing specifically with the mechanism of reduction of intussusception by gas or fluid pressure and aimed at establishing the utility and safety of this method of therapy. He was inclined to think that gas was a good deal safer than fluid but this may have been due to a certain prejudice held by him in favor of the use of hydrogen gas in surgery. He had recently demonstrated experimentally in dogs wounded by pistol shot through the abdominal wall that if hydrogen gas were insufflated into the intestine it would escape from the intestine and out the abdominal wound where its presence could be demonstrated by lighting it with a match. This test Senn recommended for use in clinical instances of penetrating wounds of the abdomen in order to permit early diagnosis of perforation of the intestine so as to justify operative intervention.

D Arcy Power in a magnificently comprehensive Hunterian lecture in 1897 described his

own experimental work with guinea pigs, cats and rabbits. He found difficulty in producing intussusception by means of cathartics and other pharmaceuticals. Intussusceptions which he produced manually were usually not dramatic in their results for his animals tolerated such intussusceptions fairly well. Nothnagel in 1904 found in cats and rabbits that steadily maintained faradic stimulation produced a tetanic contraction of bowel which occasionally caused the bowel to telescope into the segment distal to it. He was chiefly interested as was Senn in the mechanism of producing intussusception. Both of them noted that the intussusception developed at the expense of the serosa, the leading point not altering. D Arcy Power's interests were more far reaching and his observations more detailed than those of Nothnagel or Senn.

Watts and Fulton in 1931 reported the production of intussusception in monkeys by faradic stimulation of the pre motor area of the cerebral cortex.

There are a number of observations from the experimental laboratory reporting that dogs with one or another type of chronic experimental renal preparation are prone to the development of intussusception. Houck and his associates found that 11 out of 36 dogs maintained from 6 to 111 days on a low salt diet and peritoneal dialysis after a bilateral nephrectomy devel-

oped intussusception. Schje mentions intussusceptions as frequent complications in very young dogs following a constricting ligature on one renal artery.

Grollman and his colleagues found intussusceptions in 11% of 71 bilaterally nephrectomized dogs whether untreated or subjected to the artificial kidney. In Houck's studies nine of the intussusceptions were single, two were double, ten were forward and one was retrograde. The intussusceptions occurred from the 2nd to the 3rd day after nephrectomy; some progressed to gangrene and some protruded through the anus. In many of the dogs hyperemic congestion, epithelial hemorrhages and edema in the mucosa of the intestine appeared and were interpreted as the possible causes of intussusception together with visceral peritoneal irritation from the dialysis fluid. This could not be the explanation in Schje's and Grollman's animals.

Furthermore, some years ago in performing bilateral cutaneous ureterostomies in young puppies by bilateral extra-peritoneal operations we found fatal intussusception a common complication of our studies. It seems probable that renal lesions of the kind under discussion are associated with intestinal hyperperistalsis which leads with some frequency to the development of intussusception.

A great mass of clinical experience has been acquired over the past 85 years in the treatment of intussusception both by operation and by reduction with hydrostatic pressure. The bulk of this material demonstrates adequately to us by pragmatic test the safety and superiority of primary reduction by hydrostatic pressure. Two of the gravest objections raised to the method are that gangrenous bowel may be reduced and that bowel may perforate under pressure during reduction. Some years ago in association with

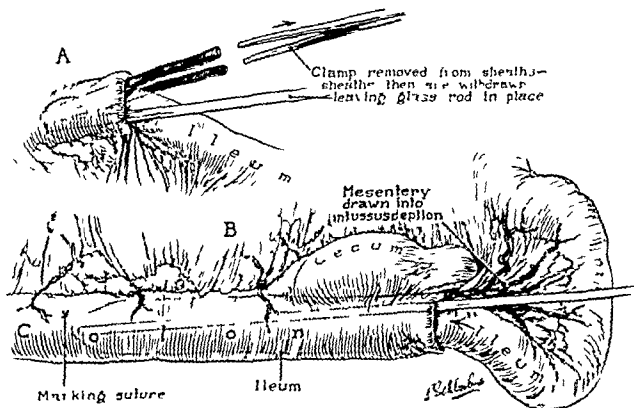


Fig. 1. Experimental Intussusception in Dogs. The ileum has been stimulated by a current from an induction coil applied some 14 centimeters from the junction with the cecum. The spastic segment has been grasped with rubber shoe forceps and invaginated into the distal bowel. A smooth glass rod is placed alongside the forceps; the

forceps are slipped out of their sheaths and the sheaths then removed. With the glass rod the intussusception is advanced 15 centimeters at the expense of the recipient loop—the intussusceptum. A silk suture in the cecum marks the level of the intussusception. (From Ravitch and McCune, *Bull. Johns Hopkins Hosp.* 87: 1918.)

Dr Robert M McCune Jr studies were undertaken to determine experimentally the likelihood of such mishaps and to observe the pathological changes in the clinical course of intussusception in animals

Attempts to produce intussusception were made by painting the ileum with barium chloride and then invaginating the contracted bowel with rubber shod clamps. In some animals prostigmine was then injected into the corresponding mesenteric artery. The prostigmine produced no obvious effect upon the intussusception. Intussusceptions produced in this manner were irreducible by enemas as soon as 7 or 8 hours later. This we attributed to the instru-

mental trauma to the bowel with resultant adherence of the adjacent coats.

The final procedure was as follows: employing adult dogs under general anesthesia and operating with sterile technique. The ileum 14 centimeters above the junction with the colon was stimulated by a faradic current from an induction coil. While the bowel was still contracted strongly it was seized by rubber shod forceps and inverted into the distal segment. If the entire intussusception was produced in this manner the serosal surfaces were sufficiently traumatized so that firm adhesions developed within 12 hours making the reduction impossible by hydrostatic pressure and difficult by di-



Fig 13 Experimental Intussusception in Dogs. Cross specimen of RM 9 dying of irreducible intussusception. The intussusciptens and intussusceptum have both been opened. Note the dilatation of the ileum proximal to the intussusception and the narrow constriction at the proximal end of the intussusception. The mucosa of the inner

most layer of the intussusceptum is well preserved and undiscolored. The outer layer of the intussusceptum is swollen, discolored, and the changes are more marked at the tip of the intussusception. The outermost layer the intussusciptens is grossly normal.



Fig. 11. Experimental Intussusception in Dogs. Cross specimen of RM 32. Irreducible intussusception at 48 hours. The outer layer of the intussusceptum is plainly

gangrenous and the changes conspicuously more advanced at the tip than proximally. (From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 82: 1918.)

Fig. 13. Experimental Intussusception in Dogs. The intussusception has prolapsed through the anus (A) and is gangrenous while within the abdomen (B) there is seen a spontaneously produced colo-colic intussusception in the same animal. The experimental intussusceptions pro-

duced presented at least as severe a condition as that seen clinically and provided a suitable test of the possible hazards of hydrostatic reduction. (From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 82: 1918.)



rect manipulation. The intussusception therefore was only initiated with the forceps (Fig 12A) the forceps then being replaced by a smooth glass rod and the intussusception completed with this instrument (Fig 12B) which was readily withdrawn without damage to the opposed serosal surfaces. Intussusceptions of some 15 centimeters in length were regularly produced. The level of the distal end of the intussusception was always marked by a silk suture in the serosa of the intussusciptions. The neck of the intussusception was usually at the ileo colic junction or just proximal to it.

Because the cecum of the dog is firmly fixed to the posterior parietes there was usually not much progression of the intussusception. In two instances the intussusception became compound developing a colocolic component which by shortening the colon permitted the intussusception of the ileum to prolapse through the anus. In two instances the intussusception was reduced spontaneously. In two others the intussusceptions did not become gangrenous and the animals suffered only from partial intestinal obstruction. All the other animals gave clinical evidence of intussusception—*anorexia*, vomiting, passage of bloody mucus per rectum and finally death unless the intussusception was reduced. In animals coming to operation the gross pathological picture was much like that in the human. In a number of dogs 6 to 8 hours after production of the intussusception 30 cubic centimeters of castor oil was given by stomach tube in the hope of aggravating the intussusception. Untreated animals usually survived over 18 hours. A total of 11 dogs succumbed to unreduced intussusceptions. Six of these intussusceptions were produced by the earlier and more traumatic method with an average survival of 71 hours. Eight others had intussusception produced by the gentler method with the glass rod and survived an average of 83 hours.

After intervals of 18, 28, 38 and 48 hours the dogs were anesthetized with ether and the abdomen reopened. The serosal surface of the neck of the intussusception was cultured. A balloon

catheter was placed in the rectum the balloon distended and saline solution permitted to enter the rectum from a height of 3 feet. The pressure was maintained for 5 minutes. If reduction was not achieved the colon was allowed to evacuate and after 5 minutes the process was repeated. If reduction was still not achieved a third attempt was made. This technique followed the clinical technique of hydrostatic pressure reduction which we employed at that time. It later became apparent that it was simpler and more effective to maintain hydrostatic pressure without remission rather than emptying the bowel repeatedly.

If the intussusception was reduced the serosal surface of the bowel was cultured again this time at the level of the original apex of the intussusception. In any case the abdomen was closed and the dog permitted to recover from the anesthesia. The majority of the dogs whose intussusceptions were completely reduced by hydrostatic pressure had uneventful recoveries the dogs in the 38 hour group experiencing the greatest difficulty. When the clinical signs of intussusception were present before reduction—*anorexia*, vomiting, listlessness, passage of blood per rectum they disappeared within 24 hours after reduction. Some dogs passed soft unformed stools for a few days afterward. Other wise the dogs remained entirely normal to gross observation. Six of the 10 dogs with irreducible intussusception of 48 hours showed a progression of their preoperative signs—vomiting, listlessness, tachycardia, passage of blood per rectum and soon became unresponsive and moribund and died 3 or 4 days after production of the intussusception. Two of the 10 dogs with irreducible intussusceptions at 18 hours had chronic intussusceptions and showed little more than occasional vomiting and constipation though one did show great weight loss by the end of two weeks. Two dogs of the 18 hour group died under anesthesia. Two dogs showing spontaneous reductions at 18 hours and the dogs successfully reduced at 48 hours recovered uneventfully. Two dogs dying in less than 18 hours before reduction could be attempted

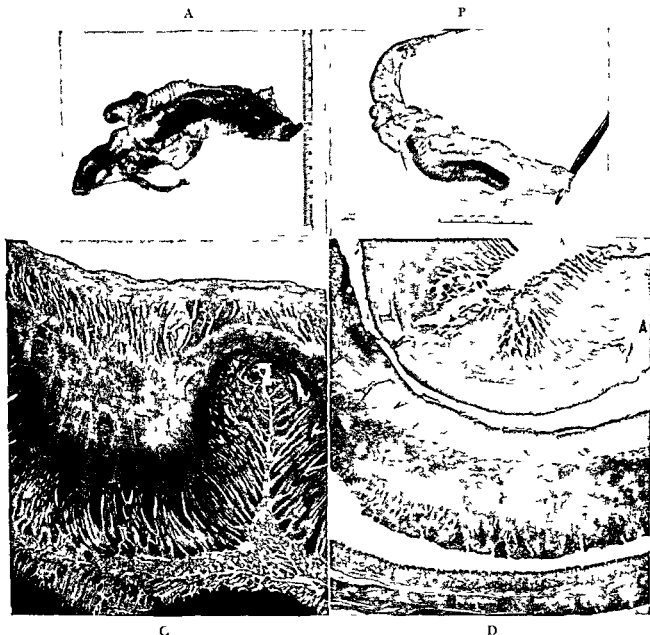


Plate I A RM 28 Experimental Intussusception in Dogs
Intussusception irreducible at 48 hours. Dog survived.
Specimen removed at 14 days. The lumen through the
intussusceptum is narrow but patent. There was no
gangrene at this time but the mucosa of the intussuscep-
tum had sloughed from the returning coat particularly
near the apex.

Plate I B RM 34 Experimental Intussusception in Dogs
Dog died at 43 hours. The apex of the intussusceptum is
gangrenous the remainder hemorrhagic and swollen.
The ensheathing intussusciptens is essentially normal.

Plate I C RM 22 (X30) Experimental Intussusception
in Dogs. Intussusception of 28 hours duration. Reduced
by enemata. Serosal cultures. All sterile before and after
reduction. The tips of the villi are sloughing and the
villi are engorged with blood. A fibrinous hemorrhagic
membrane covers the mucosa. The submucosa is tremen-
dously edematous and hemorrhagic and infiltrated with
round cells. The longitudinal muscle is relatively normal.

The serosa (not shown) is edematous and hemorrhagic
and infiltrated with a few polymorphonuclear leukocyte
among the round cells.

Plate I D RM 25 (X12) Experimental Intussusception in
Dogs. Intussusception of 36 hours duration. Dog died
at 36 hours of intussusception. Autopsied at once. The
photomicrograph shows all three layers of this intus-
usception at the time of the animal's death.

A Innermost layer of intussusceptum

B Returning layer of intussusceptum

C Ensheathing layer—the intussusciptens

The changes are less extreme than in RM 23 (Plate II A)
but one can see clearly the mucosal hemorrhage and ulcer-
ation and the submucosal hemorrhage in the returning
layer (B) of the intussusceptum. These changes are much
farther advanced and much more striking than they are
in the inner or entering layer of the intussusceptum. The
outermost layer the intussusciptens is seen to be relatively
normal.

EXPERIMENTAL INTUSSUSCEPTION IN DOGS

Table of Results

Dog	Duration of Intussusception Hr	Culture Before Reduction	Result of Treatment	Culture After Reduction	Fate
RM 16	18	Sterile	Reduced 1 enema	Sterile	Anesthetic death
RM 17	18	Sterile	Reduced 1 enema	Gram + cocci	Survived
RM 18	18	Sterile	Reduced 1 enema	Sterile	Survived
RM 21	18	Sterile	Reduced 1 enema	Sterile	Survived
RM 19	28	Sterile	Reduced 1 enema	Sterile	Survived Biopsied at 9 days
RM 20	28	Gram + cocci	Reduced 2 enemas	Gram + cocci	Survived Biopsied at 7 days
RM 29	28	Sterile	Reduced 1 enema	Sterile	Survived Biopsied at 2 days
RM 29	28	E. coli	Reduced 3 enemas	E. coli strep fecalis	Survived Biopsied at 10 days
RM 30	38	Sterile	Reduced 2 enemas	Strep fecalis	Survived Biopsied at 8 days
RM 31	38	Sterile	Reduced 3 enemas	Sterile	Survived Biopsied at 6 days
RM 33	38	E. coli	Reduced 3 enemas	E. coli	Survived Biopsied at 4 days
RM 36	38	Strep salivarius	Reduced 3 enemas	I. rostratus vulgaris strep salivarius strep equinus	Survived Biopsied at 2 days
RM 38	38	Sterile	Reduced 3 enemas	Gram—rods	Sacrificed immediately after biopsy
RM 34	48	—	Spont reduction	Sterile	Survived
RM 35	48	—	Spont reduction	Sterile	Survived
RM 36	48	Gram + cocci	Irreducible	—	Chronic intussusception Survived Biopsied at 14 days
RM 23	48	Gram + cocci	Irreducible	—	Anesthetic death
RM 24	48	Gram + cocci	Irreducible	—	Died at 96 hours
RM 28	48	Gram + cocci	Irreducible	—	Chronic intussusception Sacrificed at 14 days
RM 37	48	Hemolytic Staph. albus	Irreducible	—	Anesthetic death
RM 31	48	Salmonella Para B (post mortem)	No treatment	—	Died at 48 hours
RM 35	48	Strep fecalis E. coli	Irreducible	—	Died at 98 hours
RM 37	48	Cultures lost	Reduced 3 enemas	Cultures lost	Survived
RM 39	48	Strep fecalis E. coli	No treatment	—	Died at 47½ hours
RM 40	48	Clostridium welchii	Irreducible	—	Died at 3 hours
RM 41	48	Strep fecalis E. coli	Irreducible	—	Died at 60 hours
RM 49	48	Strep salivarius	Irreducible	—	Died at 120 hours
RM 43	48	Strep salivarius E. coli	Irreducible	—	Died at 141 hours

(From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 8, 1918.)

Fig 16 Experimental Intussusception in Dogs. Intussusceptions were produced operatively under sterile conditions and the abdomens reopened under similar conditions at the stated intervals. Cultures were taken of the serosal surfaces of the intussusceptions before reduction and of the intussusception after reduction by hydrostatic pressure

under direct visual control. It is of greatest interest that pathogenic organisms were frequently found on the surface of the intussusception and even of the intussusceptions in many animals with bowel sufficiently viable to survive even after full thickness biopsy of the bowel wall and closure of the defect.



Fig 17 RM 38 (X60) Experimental Intussusception in Dogs. Intussusception of 38 hours duration reduced by enema and the dog sacrificed at once. Cultures. Before reduction—sterile after reduction—gram negative rod shaped bacilli. In the gross the serosa was edematous and beefy. The involved mucosa was darker than normal and sharply delineated. Under the microscope one sees cellular infiltration of the well preserved mucosa. Coblet cells

are numerous. Both muscle coats show severe changes, seen most plainly in the circular muscle coat, the viability of which is doubtful in some areas. There is fibrin on the serosa. Experience with animals allowed to survive would indicate that in the face of an intact mucosa and submucosa the areas of probable necrosis in the muscle layers could be expected to heal. (From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 82: 1918.)

had courses much like the other fatal cases described above.

It will be seen from Figure 16, a tabulation of our animal experiments that whenever an intussusception could be reduced by hydrostatic pressure the animal survived indefinitely (but for one which died under anesthesia). In no instance did any animal with a reduced intussusception have peritonitis, abscess, fistula or any other complication to suggest that non viable bowel might have been reduced. In no instance did bowel reducible or irreducible rupture. In the 18, 24 and 38 hour periods the intussusceptions were all reducible and all dogs survived. In 8 instances subsequent full thickness biopsy of the intussusception was performed and followed by uneventful recovery. In the 18 hour group there were 13 dogs, excluding two whose intussusceptions had reduced spontaneously.

Only 1 of these 13 intussusceptions at 18 hours was reducible by hydrostatic pressure. This dog survived. The other 12 were all irreducible by 8 feet of hydrostatic pressure and all 12 dogs died.

The cultures taken from the serosal surfaces of the intussusceptions are of special interest and are shown in Figure 16. The following organisms were identified from these cultures: often several from one animal. *Escherichia coli*, alpha, *Streptococcus fecalis*, alpha, *Streptococcus salivarius*, *Clostridium welchii*, *Proteus vulgaris*, alpha, *Streptococcus equinus*, hemolytic, *Streptococcus albus* and *Salmonella paratyphi*. As might be suspected, while cultures were positive in 2 out of 3 dogs with intussusceptions 24 hours old or less, 5 out of 6 of the 38 hour old intussusceptions yielded positive cultures and 12 out of 12 of the 18 hour old intussusceptions yielded pos-



Fig 18 RM 33 ($\times 60$) Experimental Intussusception in Dogs. Intussusception of 38 hours duration. Reduced. Biopsied after 4 days. Cultures Before reduction—negative after reduction—*Escherichia coli*. The mucosa is injected and hemorrhagic but the villi are tall. Goblet cells predominate. There is extensive submucosal infiltration and in this instance both inner and outer muscular coats show changes of moderate degree. Changes in this animal's intestine are not as marked as in many others (From Ravitch and McCune *Bull Johns Hopkins Hosp* 82 1948)



Fig 19 RM 31 ($\times 60$) Experimental Intussusception in Dogs. Intussusception of 38 hours duration. Reduced. Biopsied after 6 days. Cultures Negative. The pathological changes are still striking. Hemorrhage and engorgement have regressed but there is a heavy cellular infiltration most marked in the thickened submucosa and in the subserosa. Again goblet cells are prominent. The internal circular muscle layer stains poorly, is heavily infiltrated with round cells and appears degenerated. The longitudinal muscle shows some cellular infiltration but the muscle fibers stand out sharply and the nuclei are well preserved (From Ravitch and McCune *Bull Johns Hopkins Hosp* 82 1948)

tive cultures. These results were anticipated by D Arcy Power who suggested in 1897 that "We do not yet know the exact course taken by the microorganisms as they pass through the wall of the bowel but there seems to be no doubt that microorganisms begin to traverse the intestinal wall when a loop of bowel has been constricted for a period of from 4 to 48 hours and that the more completely the blood supply is arrested the more rapidly they pass." It is striking that bowel as well preserved as that seen in Figure 17 of RM 38 sacrificed immedi-

ately after ready reduction of a 38 hour old intussusception permitted bacteria to pass through the wall despite well preserved mucosa and submucosa. The clinical significance of these bacteriologic findings is apparent. They must account in part for the morbidity after operative reduction of intussusceptions particularly in the pre-antibiotic era—high fever (some times seen also after non-operative reduction), abdominal abscesses, wound infections, postoperative adhesions with intestinal obstruction.

Several features emerge from the pathology

cal study of bowel recovering from intussusception. In these experiments the returning limb is regularly found severely damaged even to the point of gangrene at a time when the bowel in the entering limb is still viable. Under the conditions of our experiments and probably in intussusception beginning in the terminal ileum in patients the returning limb is cut off from its circulation by the acute kinking of the bowel as it turns on itself at the apex of the intussus-

ception. The pressure of edema should be the same on entering and returning layers but the circulation of the returning layer is further interfered with by the U turns made at the apex of the intussusception and at the neck effectively isolating this segment of bowel. The frontispiece, Figures 14 and 15 and Plate II A & B illustrate this point. The changes caused by the condition are so severe as still plainly to be seen microscopically ten days after reduc-



Fig 20 RM 20 (X60) Experimental Intussusception in Dogs. Intussusception of 28 hours duration. Reduced by enema. Biopsied 7 days later. Cultures Gram positive cocci before and after reduction. In the gross the bowel was slightly thickened. Under the microscope the villi are found engorged with blood and round cells and a few polymorphonuclear leucocytes. The mucosa is flattened and the glands distorted. The thickening of the bowel at this stage is due more to the tremendous cellular infiltration of the submucosa than to edema. The inner circular muscle layer again appears glassy and infiltrated while the external longitudinal muscle layer is well preserved. No ulceration is seen but the villi seem thinned out. There is moderate serosal edema and round cell infiltration. (From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 52 1918)



Fig 21 RM 19 (X60) Experimental Intussusception in Dogs. Intussusception of 28 hours duration. Reduced by enema. Biopsied 9 days later. Cultures All sterile. The bowel appeared normal in the gross. Under the microscope the epithelium is seen to have regenerated and appears normal but for increase in the number of goblet cells. The villi although irregular are tall. There is tremendous round cell infiltration of the submucosa and numerous engorged vessels. There are a few polymorphonuclear leucocytes among the mononuclear cells. The submucosal lymphoid follicles are greatly enlarged and contain a few polymorphonuclear cells. The serosa is thickened and there are still a few round cells and plasma cells. The circular muscle layer is still abnormal glassy and infiltrated with many round cells. (From Ravitch and McCune *Bull. Johns Hopkins Hosp.* 57 1918)

tion (Fig 22 (RM 29)) Hemorrhage and engorgement disappear first then edema and lastly cellular infiltration. The mucosa is frequently partially sloughed or eroded but ulcers through to the submucosa are not seen. Despite this fact pathogenic bacteria make their way through to the serosal surface. There is a striking difference between the survival ability of inner circular and outer longitudinal muscular coats as sharply demonstrated in the photo-

micrograph of RM 23 (Plate IIA). The inner circular muscular coat is largely destroyed and unrecognizable in the thickened returning layer of the intussusceptum while the outer longitudinal coat is relatively well preserved morphologically.

Another avenue of investigation has been the study of the pressure tolerances of the human colon. This was made necessary by such advice as that given by W. E. Forest of New York in



Fig 22 RM 29 (X60) Experimental Intussusception in Dogs. Intussusception of 38 hours duration. Reduced. Biopsied 10 days later. Culture: *Escherichia coli* alpha. *Streptococcus fecalis*. There is no more evidence of hemorrhage and engorgement. One still sees an abnormal number of goblet cells. There is some round cell infiltration of the submucosa. The inner circular muscle is almost hyaline. The outer coat shows some degenerative changes. The serosa is thickened and infiltrated with round cells and polymorphonuclear cells and shows beginning organization. Edema has entirely receded. (From Ravitch and McCune. *Bull. Johns Hopkins Hosp.* 82: 1948.)

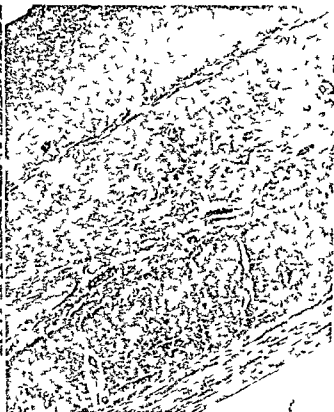


Fig 23 RM 23 (X60) Experimental Intussusception in Dogs. Intussusception of 48 hours duration. Irreducible. Animal sacrificed and specimen obtained. Serosal culture: Gram positive cocci. Only the returning layer of the intussusceptum, the middle of the three layers of the intussusception is shown. The bowel is almost entirely gangrenous. The mucosa is unrecognizable. The submucosa is tremendously thickened. The inner circular muscle is completely disorganized while the outer longitudinal layer is startlingly preserved in contrast to the general destruction of the other layer. The serosa shows only edema. The vessels do not show clots or thrombi. A low power photomicrograph showing a cross section of the entire specimen is seen in Plate III A. (From Ravitch and McCune. *Bull. Johns Hopkins Hosp.* 87: 1948.)



Fig 24 RM 30 (X60) Experimental Intussusception in Dogs Intussusception of 38 hours duration Reduced biopsied 8 days later Culture alpha Streptococcus fecalis The villi still show hemorrhage and an infiltration of mononuclear cells The submucosa is thickened and

heavily infiltrated with round cells There is once more the usual difference between the muscle coats the outer being well preserved the inner not (From Ravitch and McCune *Bull Johns Hopkins Hosp* 82 1918)

1889 He advised laying the child in the hall way inserting the enem tube and slowly ascending the stairs enem bag in hand exercising caution after ascending 10 feet !

Mortimer in England injected the colons of fresh cadavers with the ileo cecal valve ligated He found the serosa to begin to crack in some cases with five feet of pressure in most with eight feet and occasional rupture to occur with six feet of pressure Nordentoft performed similar experiments distending the bowel of dead newly born children with the ileum ligated at the ileo cecal junction The bodies had been dead from 13 to 51 hours Rupture of the bowel occurred with pressures of from three to ten meters In two cases in which the resistance of the small bowel was tested it was found to rupture after three and seven meters of pressure respectively

The 3 or 3½ feet of pressure used in patients would appear to provide a safe margin

BIBLIOGRAPHY

- Forest W E Intussusception and the use of injections *At Rec* 36 371 1889
- Houck C R Moore A W Ellison W B and Gilmer R Intestinal intussusception in chronic nephrectomized dogs maintained by peritoneal dialysis *Science* 119 815 816 1951
- Mortimer J D On the treatment of intussusception by injection or inflation and its dangers *Lancet* 1 1111 1891
- Muirhead F F Crollman A and Vinatta J Hypertensive cardiovascular disease (malignant hypertension) *Arch Path* 50 137 150 1950
- Nordentoft J M The value of the barium enema in the diagnosis and treatment of intussusception in children illustrated by about 500 Danish cases *Acta radiol Suppl* 51 1913
- Nothnagel Hermann Diseases of the intestines and peritoneum in Nothnagels *Encyclopedia of Practical Medicine* Philadelphia Saunders 1901

- Power D Arcy The Hunterian lectures on the pathology and surgery of intussusception *Brit Med J* 1 381 453 514 1897
- Power D Arcy Some points in the minute anatomy of intussusception *J Path & Bact* 4 484 1897
- Ravitch M M and McCune R M Jr Reduction of intussusception by hydrostatic pressure an experimental study *Bull Johns Hopkins Hosp* 82 550-568 1948
- Selye H Textbook of Endocrinology *Acta endocrinol* 1947
- Senn Nicholas *Intestinal Surgery* Chicago W T Keener Co 1893
- Watts J W and Fulton J F Intussusception—relation of cerebral cortex to intestinal motility in monkey *New England J Med* 210 883-896 1934

TREATMENT OF INTUSSUSCEPTION

A OPERATIVE

THE standard treatment of intussusception in this country and the British Isles and in most of Europe is immediate operative reduction of the intussusception. For a good many years great stress was laid upon the necessity for operating upon the patients within moments of their arrival in the hospital and Doctor Ladd in particular emphasized the urgent importance of instant operation. As time has passed it has become generally accepted that the immediate need of a child with intussusception is for intravenous fluids or blood for gastric aspiration is in any type of intestinal obstruction and for the administration of antibiotics is in any other situation in which there is potential jeopardy of the vascular supply of the bowel. These measures having been undertaken the abdomen is entered through the surgeon's incision of choice. Our own preference in intussusception in a situation in which the operative manipulation may begin in the left lower quadrant and end in the right lower quadrant would be for a lower midline incision (Actually our intussusceptions are almost invariably reduced to the cecum by the barium enema in that 25% of cases in which enema reduction is not complete and there a small McBurney incision suffices). The intussusception is manually located the bowel manipulated by compression just distal to the intussusception driving it proximally. If the bowel reduces easily

and rapidly there is no need to deliver the intussusception nor to question the viability of the bowel. The proper mechanism of manual reduction of an intussusception was clearly described by Hilton Fagge and Henry C. Howe of Guy's Hospital in their report in the Medical-Chirurgical Transactions for 1876. They stated the intestine was accordingly drawn out from the abdominal cavity and even then some difficulty was experienced in reducing it. Pulling at the end was quite ineffectual though as much force as was considered justifiable was exerted in this way. Under a kind of kneading movement however combined with circular pressure upon the farthest intussuscepted part of the gut it began to yield and when once started the process went on readily until the last part of the intestine was reached.

It will be seen that this method of reduction which is precisely that used today is essentially one in which the surgeon by compressing the bowel distal to the intussusception increases the pressure within the lumen of that bowel forcing the intussusception proximally in this manner. This pressure is applied much as in hydrostatic pressure reduction with an enema but the manual method of reduction is necessarily more traumatic. At times there may be encountered a substantial difficulty in operative reduction of an intussusception. In such instances it is important that the intussusception be delivered and carefully observed while pressure is being made distal to it. The first warning

of impending danger will be serosal cracking of the receiving loop of bowel as undue pressure is exerted upon it by the failure of the intussusceptum to yield. At times the manipulation may be aided by the gentle injection of sterile mineral oil between the coats of the intussusception. Attempts to stretch the neck of the intussusception with instruments invariably result in disaster and incision of the neck of the intussusception invites contamination of the operative field. In any case it will be seldom that an intussusception so difficult of reduction as to require these strenuous methods will prove not to require resection because of gangrene or doubtful viability. If therefore persistent and gentle compression of the bowel distal to the intussusception does not reduce the process resection should be undertaken. One can tell in five minutes whether the bowel will reduce and stubborn persistence at manual disinvagination is to be decried.

In view of the recognized incidence of recurrence of intussusception numerous methods have been undertaken by various surgeons to decrease the likelihood of recurrence. In general it may be said that the various attempts at fixation of the cecum and of the terminal ileum have been abandoned as not being effective and as being potentially harmful. A good deal has been written about the advisability or inadvisability of removal of the appendix at the time of reduction of an intussusception. Although the group from the Children's Hospital in Boston formerly inveighed strongly against this practice a review of current writings on intussusception would suggest that appendectomy is now more commonly performed than not at the time of operative reduction. In a review of our own material up to the time at which operative reduction became a rarity we found that patients in whom the appendix had been removed actually had a lower mortality than patients on whom appendectomy had not been performed. No complications were attributable to appendectomy.

Surprisingly enough there remains a substantial lack of agreement among the various sur-

geons interested in the problem as to the proper method of procedure when bowel is to be resected. Intestinal resections and anastomosis of any kind were fraught with an almost prohibitive mortality up to the first decade of this century. It is not surprising that in that day surgeons either refused to operate, hoping that the gangrenous intussusceptum would pass spontaneously, or attempted some minor appearing procedure rather than a bold resection and anastomosis. Such a procedure was that of Cushing seen in Figure 25. This type of half way measure is still apparently performed from time to time but with as little success as it had in Cushing's day.

Maunsell's method of resection of tumors of the bowel which was based on the deliberate production of an intussusception obviously suggested itself to those operating at the turn of the century and fearful of their ability to suture divided bowel after a resection. This method is cited only for historical reasons since unlike most of the other methods of operation which have ever been proposed for intussusception (see Fig. 26) it is now never used. In this ingenious method the entering and receiving layers of the intussusception were sutured together at the neck of the intussusception. The intussusceptum was opened by a longitudinal incision and the intussusceptum amputated from within the intussusceptum. A circular suture of the amputated base of the intussusceptum was followed by closure of the incision in the intussusceptum. As might be supposed this method did not prove to be very successful despite its ingenuity.

The drawings in Figure 26 illustrate the modes of treatment of irreducible intussusception which have been employed. These are—

1. Resection of the bowel and creation of a double barrelled ileo colostomy.
2. Exteriorization of the bowel with delayed division of the bowel (the Aseptic Mikulicz resection).
3. Primary resection with end to side ileo colostomy, the open end of the colon being left as a vent.
4. Side to side anastomosis around the intus-

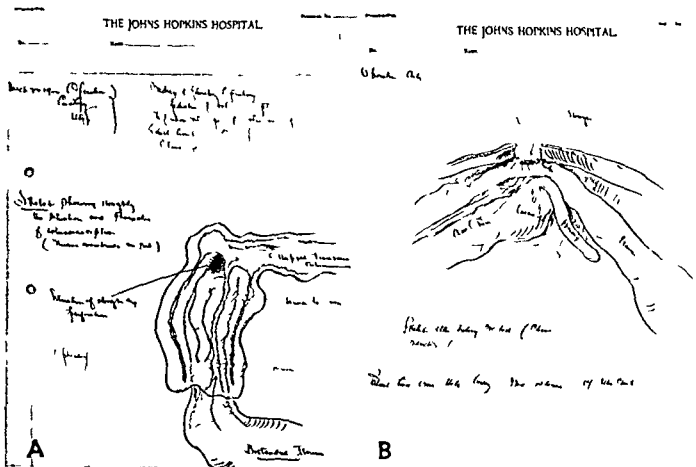


Fig. 25 Drawings by Harvey Cushing in History No. 10141 The Johns Hopkins Hospital
A Case of Intussusception

A March 22 1900

Operation	{	Median Exploratory Laprotomy
Cushing		Reduction of Intussusception
Ether		Excision at apex of intussusceptions
		Establishment at this point of artificial anus
		Chronic peritonitis

Sketch showing roughly the situation and character of intussusception (mucous membranes in red)	Collapsed transverse colon
	Serosa to serosa
	Lumen
Situation of slough and perforation	Distended Ileum
Appendix	

Intussusception in the early days of the Johns Hopkins Hospital was a highly fatal disease despite the fact that Hutchinson had already demonstrated the feasibility of operation and Hirschsprung the lower mortality associated with systematic use of hydrostatic pressure. Harvey Cushing was all his life a meticulous and careful worker. The old histories of his patients contain many examples of careful and lucid illustrations like the present one.

B Operation Cushing

Sketch illustrating method of closure after reduction of intussusception

Patient took anesthetic badly Much shocked
Of ether chart

How superior is a brief and nicely illustrated note (in two colors) like this to the impersonal formal typed operative notes which most of us leave today. The operation of course was poorly conceived. The bowel was too severely injured to be trusted beneath the abdominal wall. This patient failed to survive and the results of the employment of this procedure which are still reported from time to time have been similarly unsatisfactory. Cushing was sufficiently dissatisfied with his results in the treatment of intussusception that in 1906 when a child with hydrocephalus on whom he had attempted a subarachnoid puncture died through a metal tube developed into intussusception he advised observing the child in the hope that the intussusception would become gangrenous and would slough out spontaneously. In that instance this did not occur and the child succumbed.

susception which is left undisturbed

5 Resection and primary anastomosis side to side end to end or end to side

As the mortality of intussusception in general has decreased sharply and the frighteningly high mortality after resection of a few years ago has similarly decreased arguments favoring one or another method of treatment if based on mortality figures alone tend to lose their cogency

The most important determination to be made at operation is that the bowel is indeed non viable or that the intussusception is irreducible If after five minutes of attempts at manual reduction the bowel has not begun to move back one should assume that the intussusception is irreducible and proceed with some type of operation which recognizes this fact A good deal of experience is required to tell whether the beefy edematous thickened and indurated hemorrhagic bowel of a reduced intussusception is viable or not It is a striking fact that in institutions at which the majority of intussusceptions are reduced by barium enema the resection rate is far lower than in institutions where primary operative treatment is the rule It is entirely possible that the increased resection rate when operation is undertaken in all cases is occasioned to a considerable extent by the additional trauma to the bowel incurred as a result of the surgeon's manipulations Further it seems probable that in a good many cases bowel which is entirely viable has been mistakenly resected because of its swollen hemorrhagic appearance Two examples of the latter from our own experience have been cited and are illustrated in Plate IIC and D Needless to say if there is any doubt about the viability of bowel it must be resected although increasing experience will lead to greater accuracy in this determination There is at present no ready method for operating room determination of the viability of possibly compromised bowel

The choice of an operative method of treatment of an irreducible intussusception is swayed by the following factors

1 The desire to do as little as possible as rapidly as possible in a profoundly ill infant

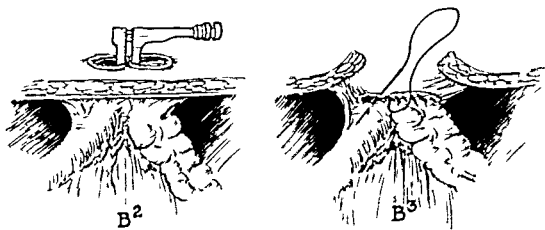
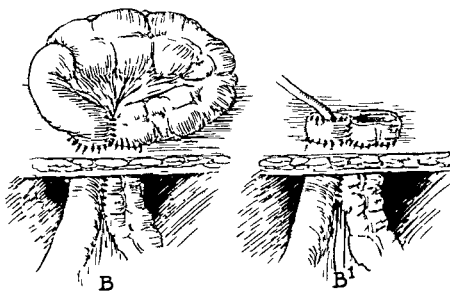
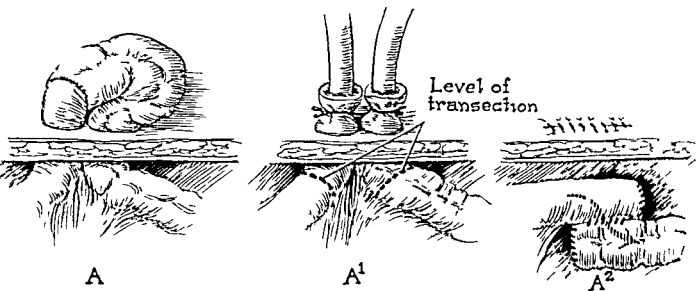
2 The desirability of avoiding the fluid losses and wound complications attendant upon creation of an ileostomy

3 Desirability of immediate restoration of continuity of the alimentary canal and

4 The avoidance of staged procedures

This is to a very considerable extent a matter of individual experience outlook and philosophy Those who have had disastrous results from attempting resection and primary anastomosis in these profoundly ill children with unprepared intestine and edematous bowel and probably contaminated peritoneal cavity are understandably prejudiced against such a procedure On the other hand as progress is made in surgery staged operations in one field after another have been given up for immediate definitive operative procedures For a long time of course it was thought that infants would not support an ileostomy with any degree of success Improved methods of management of fluid and electrolyte problems have very largely disposed of this objection to a staged procedure

Resection of the bowel in the course of the operation and bringing the bowel ends out through the wound (Fig 26A and B) is the most direct and simplest way of dealing with the problem Gross in Boston and Jones in New Castle-on Tyne have described worthwhile modifications of this basic plan Gross (Fig 26B) divides the mesentery but does not resect the bowel The loops of bowel immediately proximal and distal to the anastomosis are sutured together in preparation for the construction of a double barrelled ileo-colostomy The abdominal wall is now closed about this doubled loop the intussusception itself being entirely exteriorized With the abdomen now completely closed the proximal and distal limbs are transected between clamps and a catheter is inserted into the proximal limb for decompression A crushing clamp is applied to the spur within a few days and the enterostomy is closed within six or seven days Cross reports 11 cases treated in this way with 11 recoveries a mortality of 23% Eleven of these patients were treated in the nine years between 1939 and 1948 with



recovery in ten and a mortality of 9%. The ages of the successfully operated children range from three days to seven years. Jones writing in 1903 reported 82 intussusceptions reduced by primary operation with no deaths six spontaneous reductions and six chronic intussusceptions operated upon with no deaths. In addition there were nine instances in which resection was required. The loop of involved bowel was brought out through the wound (Fig 26A) the bowel loops not being sutured together the abdomen was closed and the bowel resected. Forty eight hours later the exteriorized ends of the bowel were resected and closed and a side to side anastomosis performed. In these nine cases there was a single death. He excluded from consideration a case in which the entire colon was necrotic and required resection with ultimate fatal outcome. A later report by Court and Jones adds one more successful case.

This method would appear to have all the advantages of Gross's method and to be moving much closer to the primary anastomosis since the reconstitution of the continuity of the bowel is achieved in two days. The results could hardly be improved upon.



Fig 26 Operative Treatment of Intussusception

A A1 and A2—The method of Jones of Newcastle

A—The entire intussusception is brought outside the abdomen the abdominal wound closed

A1—Both loops are amputated and tubes are tied into the bowel. The dotted line indicates the site of proposed transection of the bowel the edematous exteriorized ends being removed 48 hours after the original operation and a side to side anastomosis performed as in A2

Jones reports ten cases with a single death

B B1 B2 and B3—The Aseptic Mikulicz procedure of Gross

B—The entire intussusception is exteriorized the mesentery divided the afferent and the efferent limbs sutured together and the wound closed

B1—Both loops are amputated. The proximal limb is decompressed by means of a catheter

B2—Within a few days the spur is crushed by a clamp and on the sixth or seventh day the remaining enterostomy wound is closed by an essentially extra peritoneal operative procedure

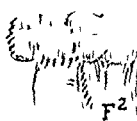
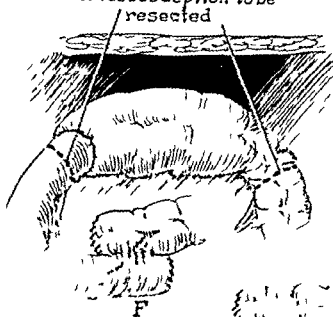
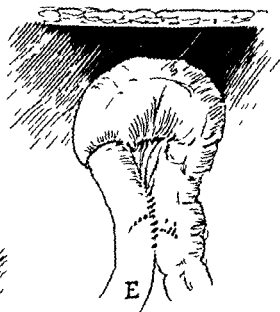
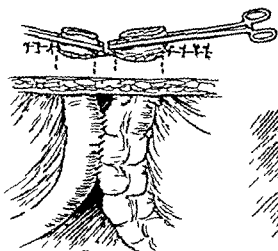
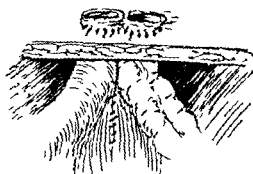
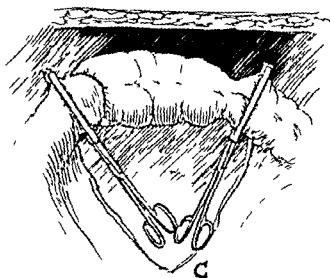
Gross reports 14 cases with 11 recoveries and of these in the years 1909 to 1918 eleven cases with ten recoveries.

The chief advantage over primary anastomosis would appear to be in the improvement in the edematous state of the distended proximal bowel and in the certainty that after 48 hours any bowel apparently viable had survived the jeopardous period of progressing infarction.

It is not surprising in consequence of the fact that the bowel which presents to view in an irreducible intussusception is almost always viable that surgeons have from time to time been tempted to perform anastomoses around the intussusception leaving it in situ. Parry in 1909 and Rutherford in the same year reported successes by this method and Montgomery and Musil in 1930 revived the method which is from time to time referred to as the Montgomery operation (Fig 26E). White and Dennison at the Royal Hospital for Sick Children in Glasgow are among the more recent advocates of this method. In four of their cases a simple anastomosis was performed around the intussusception and all the bowel returned to the abdomen. The subsequent courses of these children demonstrated that in two cases the intussusceptum sloughed and was passed with satisfactory function of the intestine from the time of operation. In one case which subsequently died of leukemia and was autopsied the intussusception apparently remained in situ but revascularized. In the 4th case the intussusception apparently reduced itself and a barium meal followed its normal route. Dennison and some of the earlier authors in bypassing the intussusception advise suturing the neck of the intussusception to prevent its further advance.

After Dennison's first report in 1918 White and Dennison in 1902 reported a total of 16 patients in whom a primary anastomosis was performed without resection of the mass. In six of these the mass was exteriorized at the time because it was thought to be gangrenous through to the outer coat. White and Dennison make the point that they have never seen death from peritonitis in unreduced intussusception and that death occurs from intestinal obstruction and toxemia. For this reason they feel that the return of the irreducible mass into

INTUSSUSCEPTION IN INFANTS AND CHILDREN



(Continued on next page)
(Legend on page opposite)

the peritoneal cavity after a simple anastomosis does not violate surgical principles. They also emphasize the fact that a substantial number of the resections are required not because of the basic extent of the pathological process at the time the patient is brought to the operating room but because of the damage inflicted by attempts at manual reduction. Of their 16 cases four died. Four of the six patients with exteriorized bowel required a subsequent hemicolectomy. In one of the patients with exteriorized bowel the intussusception could be reduced subsequently and was returned into the abdomen with success. In another such case the baby aspirated vomitus and died after the second small operative procedure on the second day. The other three deaths were in children who had simple anastomoses and are described as having been due to bronchial pneumonia to shock and to toxemia respectively.

In connection with the work of White and

←←←

C and C1—Direct resection of the intussusception and performance of a straightforward double barrelled ileo colostomy

D—The method of Woodhall—the intussusception has been resected. Continuity of the bowel has been restored by a side to side anastomosis and the ends of the bowel have been brought out as decompressing vents which will close spontaneously or can subsequently be closed by a few sutures.

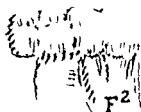
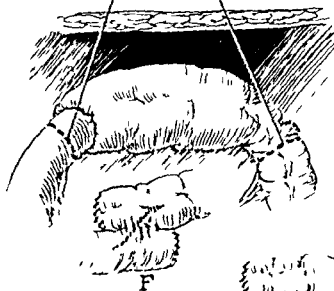
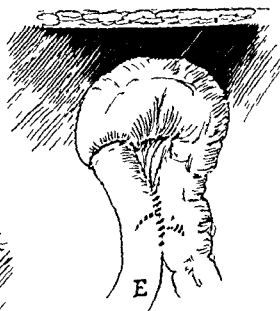
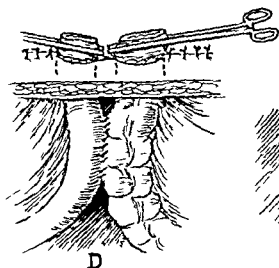
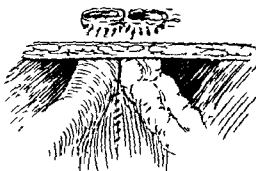
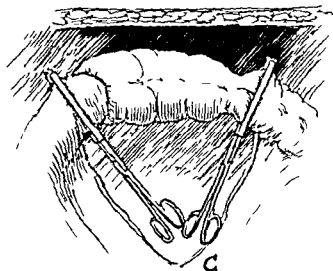
E—The procedure of Parry (1909) and of Rutherford (1909) revived by Montgomery (1930) and presently advocated by White and Dennison. The intussusception is left in situ and a side to side anastomosis performed between the afferent and efferent loops. White and Dennison report 16 cases with 1 death.

F and F2—Resection and primary anastomosis either side to side (F) end to end (F1) or end to side (F2). This is the most straightforward and definitive procedure. This is the preferred method of Dennis, of Benson and Sharp, of Jackard and Allen, of Zachary, of Fox, of Thatcher and others and seems to be becoming established as the procedure most frequently advocated and performed.

Mentioned only for the sake of historical completeness is Maunsell's operation. Here the neck of the intussusception is sutured, the intussusciens incised, the intussusceptum amputated, the transected edges of the intussusceptum and intussusciens flipped over and the incision in the intussusciens then closed.

Dennison it is important to point out as Jones and others have stated that occasionally necrosis is found and recognized in the ensheathing layer and when this is the case quite obviously a simple short circuiting procedure cannot be performed. Whether one would choose then as White and Dennison have chosen to perform an intra abdominal anastomosis with exteriorization of the bowel and of the intussusception without resection is a matter for individual judgment. From the report of White and Dennison it seems that very little is gained by leaving this mass of bowel outside of the abdomen for a time. It is of interest in White and Dennison's patients that after two months there was not in any case any radiologically demonstrable evidence that the short circuiting anastomosis was functioning and the implication is that the normal channel had been reconstituted and that the anastomosis had ceased to function. One's reaction is that this is an essentially unsurgical procedure and that one is loath to leave a potentially gangrenous lesion in place and that in general in intestinal surgery short circuiting intestinal operations which do not deal definitively with the primary lesion are unsatisfactory. Unfortunately for such a priori judgments the method does work and the results are entirely acceptable. It may prove that the risks of leaving the involved segment of bowel behind are no greater than the risks assumed in performing more complicated operative procedures and anastomoses.

In order to combine the advantages of removal of the intussusception and restoration of the continuity of the intestinal tract in one stage with the decompressive benefits of the Mikulicz type of operation Woodhall (Fig 26D) at the suggestion of Dean Lewis resected the intussusceptum performing a side to side anastomosis bringing out the ends of the transected bowel as temporary vents. This had the double advantage of decompressing the proximal intestine and minimizing the danger or consequence of leakage from an anastomosis in edematous bowel. As the anastomosis began to function these vents closed spontaneously or could be



(Continuation next page)
(Legend on page 10)

the peritoneal cavity after a simple anastomosis does not violate surgical principles. They also emphasize the fact that a substantial number of the resections are required not because of the basic extent of the pathological process at the time the patient is brought to the operating room but because of the damage inflicted by attempts at manual reduction. Of their 16 cases four died. Four of the six patients with exteriorized bowel required a subsequent hemicolectomy. In one of the patients with exteriorized bowel the intussusception could be reduced subsequently and was returned into the abdomen with success. In another such case the baby aspirated vomitus and died after the second small operative procedure on the second day. The other three deaths were in children who had simple anastomoses and are described as having been due to bronchial pneumonia, to shock and to toxemia respectively.

In connection with the work of White and

←

C and C1—Direct resection of the intussusception and performance of a straightforward double barrelled ileo colostomy.

D—The method of Woodhall—the intussusception has been resected. Continuity of the bowel has been restored by a side to side anastomosis and the ends of the bowel have been brought out as decompressing vents which will close spontaneously or can subsequently be closed by a few sutures.

E—The procedure of Parry (1909) and of Rutherford (1909) revived by Montgomery (1930) and presently advocated by White and Dennison. The intussusception is left in situ and a side to side anastomosis performed between the afferent and efferent loops. White and Dennison report 16 cases with 1 death.

F F1 and F2—Resection and primary anastomosis either side to side (F) end to end (F1) or end to side (F2). This is the most straightforward and definitive procedure. This is the preferred method of Dennis of Benson and Sharp of Packard and Allen of Zachary of Fox of Thatcher and others and seems to be becoming established as the procedure most frequently advocated and performed.

Mentioned only for the sake of historical completeness is Maunsell's operation. Here the neck of the intussusception is sutured the intussuscipts incised the intussusceptum amputated the transected edges of the intussuscipts and intussuscipts whipped over and the incision in the intussuscipts then closed.

Dennison it is important to point out as Jones and others have stated that occasionally necrosis is found and recognized in the ensheathing layer and when this is the case quite obviously a simple short circuiting procedure cannot be performed. Whether one would choose then as White and Dennison have chosen to perform an intra abdominal anastomosis with exteriorization of the bowel and of the intussusception without resection is a matter for individual judgment. From the report of White and Dennison it seems that very little is gained by leaving this mass of bowel outside of the abdomen for a time. It is of interest in White and Dennison's patients that after two months there was not in any case any radiologically demonstrable evidence that the short circuiting anastomosis was functioning and the implication is that the normal channel had been reconstituted and that the anastomosis had ceased to function. One's reaction is that this is an essentially unsurgical procedure and that one is loath to leave a potentially gangrenous lesion in place and that in general in intestinal surgery short circuiting intestinal operations which do not deal definitively with the primary lesion are unsatisfactory. Unfortunately for such a priori judgments the method does work and the results are entirely acceptable. It may prove that the risks of leaving the involved segment of bowel behind are no greater than the risks assumed in performing more complicated operative procedures and anastomoses.

In order to combine the advantages of removal of the intussusception and restoration of the continuity of the intestinal tract in one stage with the decompressive benefits of the Mikulicz type of operation Woodhall (Fig. 26D) at the suggestion of Dean Lewis resected the intussusceptum performing a side to side anastomosis bringing out the ends of the transected bowel as temporary vents. This had the double advantage of decompressing the proximal intestine and minimizing the danger or consequence of leakage from an anastomosis in edematous bowel. As the anastomosis began to function these vents closed spontaneously or could be

closed by a small extra peritoneal operation

Finally, there is the direct primary anastomosis (Fig 26F) usually end to end which most writers are coming to accept

In irreducible or strangulated intussusception it is self evident that a one stage resection and primary anastomosis would be the most desirable procedure if it could be safely performed. That is actually the direction in which most surgeons reporting their experiences today are tending with the notable exceptions given above. Our own experience with resection is essentially in old one and so few resections are now required on our service as to allow no conclusions. Our present practice in bowel resection in infants for other causes is entirely in favor of a primary one stage anastomosis. In a review of the entire material of The Johns Hopkins Hospital from 1889 to 1948 there were 32 operative procedures for gangrenous or irreducible intussusception. In nine instances the bowel was resected and an immediate anastomosis performed. Seven of these patients died, the first one being in 1899 of a breakdown of the anastomosis. Most of the deaths appeared to be of shock and infection and not due to a suture line breakdown with the exception of the case done in 1899. In four cases the intussusception was reduced and an enterostomy performed. All four of these patients died. In one case the bowel was extraperitonealized and the patient died. In seven instances bowel of questionable viability was inverted in order to avoid the larger operation of resection. Three of these seven patients died. All three of these deaths occurred in the immediate post operative period and all were apparently due to the desperate condition of the patients at the time of operation. Eight patients were treated by a Mikulicz type of resection, one before 1930 with death, seven since 1930 with one death. Five of these were of the ordinary Mikulicz type and three of the eight were done by the modification described by Woodhall. Again these two deaths occurred two to three hours after operation being, apparently

attributable to the condition of the child at the time of operation and to the operation and not to loss of fluids from the ileostomy. The two patients operated upon by Woodhall both recovered as did a third child with a side to end anastomosis, the end of the ileal segment being brought out as an ileostomy. This fistula was closed seven days later.

In the ten years January 1918 to January 1938 we have had 52 intussusceptions at The Johns Hopkins Hospital and no deaths. Of these only two had bowel resections, one in 1919 in a seven month old infant for an enteric cyst at the ileo cecal valve which had caused a reducible intussusception and one in 1937 in an infant of four months with an irreducible intussusception reaching to the hepatic flexure (Fig 27). Primary resection and anastomosis was performed in both infants without event.

The reported mortality of intussusception in those cases which required resection has been extremely high until very recently and it is small wonder that surgeons have shied away from primary anastomosis, believing that these required larger operations and longer procedures in extremely sick children. Benson and Sharp, reporting their experience at The Children's Hospital of Michigan in 1930, reported five children with intussusception resected during the previous three and a half years with primary anastomosis and a single death due to necrosis and leakage at the suture line. Some of their anastomoses were end to end, some end to side, some side to side. The fatal case had a side to side anastomosis. They feel that side to side anastomosis is preferable for infants younger than four months, after which age the size of the bowel begins to make end to end anastomosis feasible and practical. Dennis, writing from the University of Minnesota, reported eight resections for intussusception between 1910 and 1917 with primary end to end anastomosis using the closed technique. He had no deaths. Packard and Allen, writing from The Denver Children's Hospital, report nine resections for intussusception with no deaths. Primary anas-

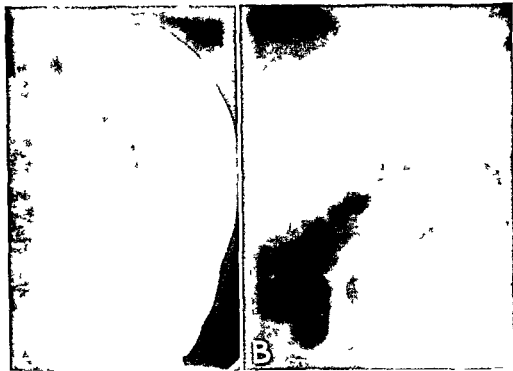
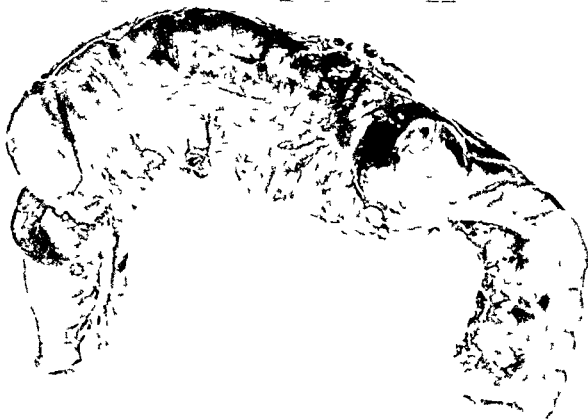
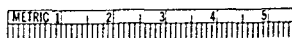


Fig 2. Incomplete Barium Enema Reduction Resection of Intussusception End-to-end Anastomosis. K. K. Female 5 months old. Intussusception in 24 hours duration. A The barium column stops abruptly just proximal to the splenic flexure. There is a vague filling defect. B The intussusception has been reduced across the midline. This is an occasional case in which barium seems to enter a short distance into the lumen of the intussusception producing a conical barium shadow.

C & D The intussusception was reduced into the ascending colon and could be reduced no further. Note the almost completely transverse cut-off of the barium column. The complete absence of barium between the layers of the intussusception suggests a tight and irreducible intussusception. In fact operation undertaken at this point revealed an intussusception which resisted attempts at manual reduction.

(Continued on p. 1542)

**E**

(METRIC)

**F**

tomosis was performed in all. There is no difficulty in finding reports usually somewhat earlier than these listing prohibitively high mortalities from resection for intussusception. Snyder Kraus and Chaffin writing from Los Angeles Children's Hospital in 1949 report a 66% mortality in patients requiring resection. Gibbs and Sutton in 1943 reported a 71% mortality in patients requiring resection. In their hands resection and primary anastomosis yielded a mortality of 43% whereas Mikulicz resection produced a 100% mortality. Gibson and associates reporting from the Mayo Clinic in 1949 had a mortality of 50% in patients requiring resection and primary anastomosis and had one survival after a Mikulicz resection. Hogg and Donovan from Babies Hospital in New York in 1946 reported nine resections for intussusception. Three out of five with primary resection and anastomosis succumbed and two out of the four with Mikulicz resection died. McLaughlin in 1948 reported resection in 21 cases with a mortality of 50%. Gross and Ware writing in 1948 reported 18 cases with primary resection and lateral anastomosis with only three recoveries, a mortality of 83%. These had all been performed more than ten years before the report and these results were the basis for the abandonment of primary resection and anastomosis at the Children's Hospital in Boston. In 1953 Gross had performed 18 Mikulicz operations by

the technique described above and had fifteen recoveries.

Lawrence and Ulfelder reported from the Massachusetts General Hospital in 1952 five resections with anastomosis for irreducible intussusception with one death.

Zachary prefers a generous resection with end to end anastomosis by a closed technique and decries either the aseptic Mikulicz procedure or other Mikulicz procedure or the addition of a lateral anastomosis to such a procedure according to the method used at Newcastle on Tyne.

Fox in 1956 from the Children's Memorial Hospital in Chicago reported ten resections with primary anastomosis and one death.

Thatcher reporting from the Milwaukee Children's Hospital in 1954 reported 15 resections with primary anastomosis since 1947 with one death, a 6.6% mortality.

In no single series is the number of resections required sufficiently large to make a comparison of result statistically significant. In the small series of resections with which we thus have to deal random sampling of a few more profoundly ill patients in one clinic than in another may seriously color the results. It would appear probable that as good results can be obtained by primary resection and anastomosis as by a Mikulicz exteriorization procedure. It certainly appears to be established that if a Mikulicz procedure is to be performed an anastomosis may be performed at the same time by the method of Woodhill leaving one or both loops of bowel open as a vent or the double barrelled ileostomy may be taken down after 48 hours and the exteriorized ends resected and an anastomosis performed by the method of Jones or a double barrelled ileocolostomy may be performed the spur crushed and the bowel anastomosed some time later—the method of Cross.

All of these methods are appreciably less tidy than a direct anastomosis and seem not to produce demonstrably better results. It is to be expected that there will be a gradual trend towards general adoption of the one stage definitive procedure. The short circuiting procedure presently advocated by the Glasgow group also

←←

E. The intact specimen the ileum entering the intussusception at the left.

I. The specimen has been split and the view is that of the interior of the portion visible in E. which has now been turned over so that the intussusciens is at the left and the entering ileum at the right. Notice the apparent good condition of the proximal ileum and the tremendous thickening of all coats of the returning limb of the intussusceptum and the beginning slough of the mucosa. The intussusciens is distended and thinned out but intact. The appendix also visible in E. has just begun to be drawn into the intussusception and its distal portion shows changes in color.

An end-to-end anastomosis was performed. The child recovered uneventfully and left the hospital in ten days.

represents a less than definitive operation which does not have the appeal of the primary resection and anastomosis nor results sufficiently better than reported by the other methods to warrant its adoption.

Above all it must be stressed that children with intussusception are sick individuals, that they are suffering from substantial fluid loss, loss of electrolytes and blood into the lumen of the bowel into the bowel wall and into the peritoneal cavity even before operation has been undertaken and that bacterial transmigration through the bowel wall begins even in a stage when the bowel is still viable. No operative method will yield good results if time is not taken first for swift and efficient attention to correcting and counteracting these factors. No child with intussusception should be operated upon without having at least received intravenous fluids and any child who is at all prostrated should receive blood. This should be in the amount of 15 cc per kilogram of body weight. If blood has not been administered and operation discloses the need for resection, blood transfusion should be begun as soon as all patients having been matched for transfusion in any case. All such children should be operated upon with an intravenous drip running. As in all operations for intestinal obstruction, most particularly in infants who strangle so readily on vomitus the stomach should be emptied by stomach tube before operation is begun and suction maintained on the gastric catheter throughout the operation. Antibiotic administration should be begun before the child is taken to the operating room. This serves to counteract the effect of the bacterial invasion caused by the primary condition, the potential soiling at operation and possible pulmonary infection. In the fast moving field of antimicrobial therapy specific recommendations are likely to have only a fleeting validity. Our present preference is for a combination of penicillin and streptomycin.

Post-Operative Therapy

Treatment after operation is guided essentially by the same indices in the child who has

had a simple operative reduction of an intussusception and the child who has had a resection. Gastric suction is maintained from the time of operation and the child treated as if he had an established intestinal obstruction. As soon as the child has passed a stool the suction is discontinued and the child begun on oral feeding. In the simple reduction of an intussusception this will usually be within 24 hours. After resection it may be a matter of several days. At all events nothing is given by mouth until the child has demonstrated by the passage of stool that the intestinal canal is open and functioning. Until this time the fluid balance is maintained by the administration of intravenous fluids to the amount of 100 to 150 cc per kilogram of body weight per day. We prefer a lactate saline glucose solution for ordinary purposes. This consists of one part M/6 lactate, two parts 0.85% NaCl and three parts 5% glucose in water. In profoundly ill children with resections and severe fluid losses it may be well to add potassium chloride 1.5 gms/1000 cc of solution. Blood may occasionally be needed in the post-operative period in children who have had a resection.

B Non Operative

The first successful operative reduction of intussusception in an infant was reported by Jonathan Hutchinson in 1873, the patient having been operated upon in 1871. Until this time the disease had been treated either expectantly waiting for gangrene of the intussusception and spontaneous passage of the slough or had been treated by rectal instillations.

The method of treatment by rectal instillations is older than any operative one. Hippocrates and Praxagoras advised forced injection of water or air into the intestines in all forms of ileus without having described intussusception and a number of authors in the early nineteenth century advised and used clysters successfully for intussusception. Others used bellows or connected hydrogen generators with the rectum or inserted effervescent powders into the rectum or inverted bottles of charged water injecting carbon dioxide under pressure. Still others

Intussusceptions at The Johns Hopkins Hospital 1939-1957

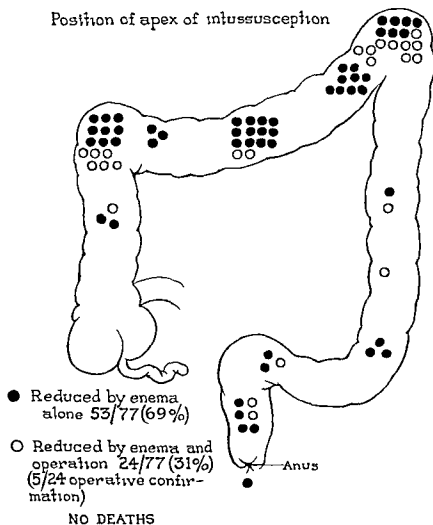


Fig. 28 Seventy seven Cases of Intussusception Treated Primarily by Barium Enema at the Johns Hopkins Hospital 1939-1957 Inclusive. Note that the position of the intussusception when encountered by the barium enema has little or nothing to do with reducibility. Of those cases

operated upon five were found to have had their intussusceptions completely reduced by the barium enema so that the barium enema reduced 53/77 or 75%. Of the 19 others operated upon in all but one the barium enema had reduced the intussusception to the cecum.

ers passed long bougies in the attempt to perform a direct reduction or stimulated the prolapsed intussusceptum with electricity or tried to shrink it with cold water or hypertonic saline solution. With this background Hirschsprung of Copenhagen in 1876 reported his experiences with the systematic treatment of intussusception in infants and children by hydrostatic pressure. By 1901 Hirschsprung was able to report on 107 personal cases of intussusception. His results were so superior to any previously

reported that his contemporaries seem to have doubted his conclusions. He appears to have been forced in self defense to publish a concise account of each of his 107 cases. He presented a 3.5% mortality in a disease which up to that time was fatal in over 80% of the cases. In 81 patients treated by Hirschsprung with enema alone the mortality was 2.3%. These figures compare favorably with those from The Johns Hopkins Hospital using operative treatment only in the period from 1929 to 1978 more

than 25 years after Hirschsprung. The method of reduction by hydrostatic pressure was systematized by the Danish school Hirschsprung and his successors Koch and Oerum and Monrad. All of these practiced to varying degrees, manual disimpaction of the intussusception through the intact abdominal wall. In 1913 and 1914 the first reports of intussusception diagnosed by roentgenography were made by Ladd and by Lehmann. In 1927 Olsson and Pällin in Sweden, Stephens and Retan in the United States and Poulhiquen in France all reported reductions of intussusception by barium enema under fluoroscopic control. Clubbe of Sydney, the great Australian student of intussusception while favoring operative reduction of intussusception in his early cases used an injection of warm oil maintaining that it always reduces the intussusception to a certain extent and in the best and gentlest possible way. In this way it lessens the shock of the coming operation because less manipulation of the intestines is needed. It is especially useful in cases in which we find the intussusception in the rectum because if we do not use it we may find some difficulty in getting our fingers below the tumor to begin the squeezing process. Hipsley, also of Sydney, Australia dissatisfied with a mortality of 8% with the operative treatment of intussusception began the regular treatment of intussusception by hydrostatic pressure with normal saline solution. In 1926 Hipsley reported his first series of 100 cases so treated with the spectacularly low mortality rate for that time of 5%. Since that time use of saline enemata has continued to be standard in a number of Australian clinics but the use of barium enema has been popular in Scandinavia and in South America. In this country and in England and Germany the use of hydrostatic pressure has never been widely accepted although in recent years there have been noticeable some concessions in its direction by those who previously resorted solely to operation.

The addition to hydrostatic pressure reduction of manipulation through the intact abdominal wall has been noted in Copenhagen and

elsewhere to result in occasional rupture of the bowel and for this reason that is to be strongly condemned. Our own experience with hydrostatic pressure has been limited entirely to the use of the barium enema reduction and dates from 1939. From 1939 to 1946 the use of the barium enema became increasingly the method of choice in the treatment of intussusception at The Johns Hopkins Hospital and since 1946 it has been universally the method of choice. The demonstration that during the period 1939 to 1947 there were 21 primary operative reductions with five deaths a mortality of 24% and 27 primary enema reductions with no mortality had a good deal to do with influencing the practice of the surgical service. Prior to that time selection of method depended upon my personal success in persuading the individual surgeon in charge of a given case. Since that time it has been standard practice to institute barium enema in all cases suspected of having intussusception. The Johns Hopkins series consists of 77 cases of intussusception in infants and children treated primarily by barium enema from 1939 to 1958. We have had no deaths in the series. During the three years 1942-1945 at the Mount Sinai Hospital in New York when barium enema reduction of intussusception was the method of choice there was a single death. This was in a child in whom the intussusception could not be reduced by barium enema and in whom operation was resorted to without delay. It is apparent from the record that the intussusception was reduced with some difficulty at operation and that non-viable bowel was judged to be viable and left behind. The patient's condition steadily worsened and the patient died without reoperation. At autopsy the bowel which had been involved in the intussusception was found frankly necrotic. At the Baltimore City Hospital where barium enema reduction of intussusception is now standard practice we have also had one death in a child treated by enema primarily. This was a premature infant six weeks of age who had had diarrhea with some bleeding for most of its brief life and who had been sent to the City Hospitals in a moribund state.

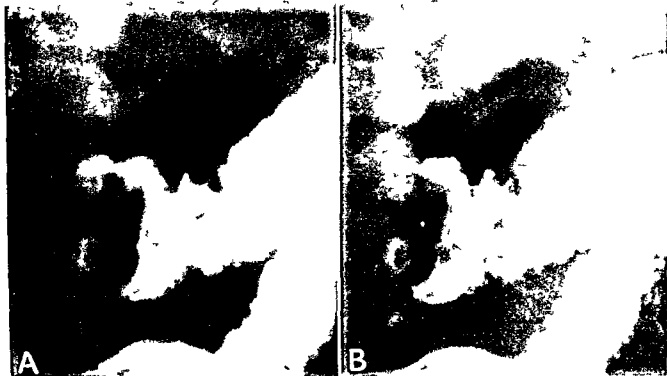


Fig 29 Reduction by Barium Enema Alone M J Female sixteen months old This infant awakened at 4 00 a m crying with pain drawing up her legs and began passing bloody stools shortly afterwards at the same time that she began to vomit Seen nineteen hours after the onset she was vigorous not prostrated There was resistance in the right upper quadrant where a sausage shaped mass could be felt extending across the epigastrium There was bloody mucus in the rectum

A Shows the intussusceptum encountered in the transverse colon to the left of the vertebral column The meniscoid defect produced by the filling defect of the intussusceptum and the extension of the horns of the meniscus up into the space between the intussusceptum and the intussusciens are beautifully shown

B The intussusception has begun its reduction and has been displaced almost to the vertebral column

(Continued on next page)

It had diarrhoea distention tracheo bronchitis and bilateral pneumonia Despite the continuing diarrhoea after two days because there was a good deal of blood in the stools a barium enema was advised This was interpreted as showing no intussusception The review of the films showed poor filling of about three inches of the small bowel and an intussusception originally present in the colon (Fig 11) Operation was undertaken at once No intussusception was found An annular cyanotic mark thought probably to have been caused by the neck of an intussusception was found about two feet above the ileo caecal valve There was no hemorrhage or edema

The baby continued in its marantic and moribund state and died two days later This intus-

susception was almost agonal in an infant already moribund and was so rapidly reduced that the original observers doubted its existence Autopsy showed an extensive and severe enteritis involving all the intestine as well as a severe bilateral pneumonia and a diffuse tracheo bronchitis

Technique of Barium Enema Reduction

As soon as the diagnosis of intussusception is suspected the operating room is notified and the patient formally posted for operation In most cases the intussusception has been reduced before the operating room has had time to send for the patient Intravenous fluid administration is begun at once in almost all children As in any type of intestinal obstruction the stomach is emptied and the gastric tube left

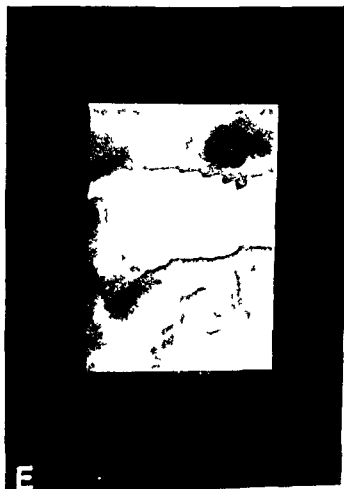


Fig. 9 (Cont.)

C The concave filling defect has almost disappeared as the intussusception has moved across the vertebral column and



D The meniscus is re-forming once more to the right of the vertebral column



E The intussusception has been reduced almost to the hepatic flexure and the meniscus is re-forming once more



F The barium has passed beyond the hepatic flexure and a

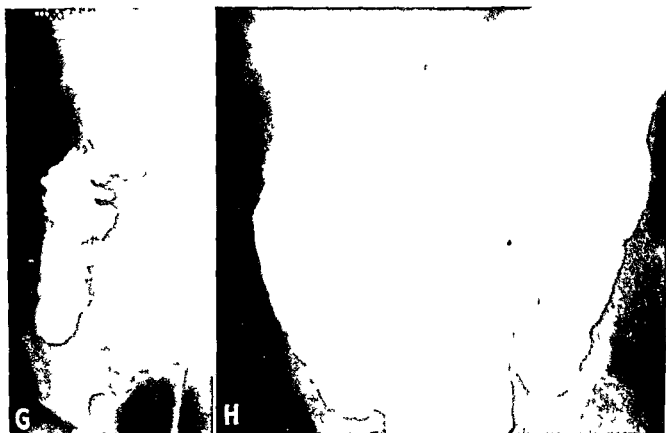


Fig. 9 (Cont)

G Begins to fill the ascending colon but no barium is seen in the ileum and the cecum is certainly not completely filled

H The abdomen is so completely obscured by barium that it might be difficult to be certain that there were

loops of small bowel which had been filled. With a little care actually one loop of small bowel can be seen lateral to the mid ascending colon and several loops of small bowel can be seen immediately beneath the middle of the transverse colon

in place. Although it has not occurred in our experience the vomiting and aspiration of vomitus by an infant in the dark of the fluoroscopic room which might otherwise occur could pose a serious problem. In the more severely shocked children blood is matched and blood transfusions begun actually in the fluoroscopic room. An ungreased 45 cc Foley bag catheter is inserted into the rectum, the balloon inflated fully and the buttocks strapped tightly together with adhesive. It is remarkable to see how large a balloon a tiny infant can expel if it struggles. The catheter is connected to an ample reservoir of barium at a height of between three feet and three feet six inches above the table. We do not employ anesthesia or sedation. In a single instance the patient was a six year old girl who but the author is the manipulation

was begun. In this instance upon mature reflection it was decided to use general anesthesia. The barium is permitted to run into the rectum uninterruptedly although at times the flow may be momentarily halted while spot films are exposed. The barium will usually be seen to run rapidly into the rectum and colon until the head of the barium column meets the point of the intussusception. At this point the rounded head of the advancing barium column suddenly becomes concave forming a meniscus round the head of the intussusception much as would a column of barium in the vagina outlining the cervix. For purposes of documentation we usually obtain a film of the intussusception when first encountered and at least one more to show complete reduction. As the hydrostatic pressure of the column of barium suspen-

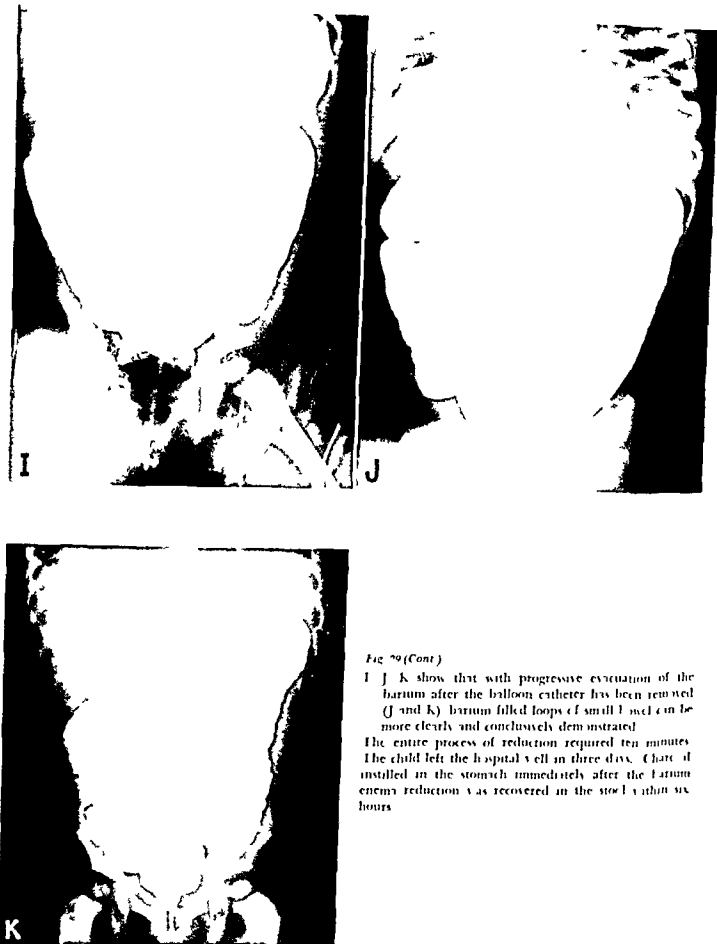


Fig 79 (Cont)

I, J, K show that with progressive evacuation of the barium after the balloon catheter has been removed (J and K) barium filled loops of small bowel can be more clearly and conclusively demonstrated.

The entire process of reduction required ten minutes. The child left the hospital well in three days. Charcoal instilled in the stomach immediately after the barium enema reduction was recovered in the stool within six hours.



Fig 30 Reduction by Iarium Enema Alone P C Female 3 $\frac{3}{4}$ years old This child entered the hospital 14 hours after the onset of abdominal pain and vomiting. She had vomited repeatedly no stool had been passed. She was prostrated and listless dehydrated with markedly sunken eyes the odor of acetone on her breath and three plus acetone in her urine The abdomen was soft and a transverse sausage shaped mass was visible and palpable in the epigastrium measuring about 8 x 3 centimeters and

firm in consistency On barium enema the intussusception was met to the left side of the transverse colon and readily reduced with free filling of the ileum within 15 minutes

A The characteristic filling defect in the head of the barium column is seen just proximal to the splenic flexure

1 The meniscus is found flattened as the barium reduces it to the right of the vertebral column

sion is maintained the meniscus lengthens the horns extending proximally around the intussusceptum until suddenly the intussusception is displaced and the meniscus flattens out again. This process is repeated sometimes with extreme rapidity until the intussusception is reduced to the cecum and through the ileo cecal valve. In the transverse and ascending colon the intussusception frequently fits loosely enough in the larger caliber intussuscipts so that barium seeps between the intussusceptum and the intussuscipts producing the coiled spring appearance even in acute intussusceptions. One should take care to see that the barium flows freely into the ileum. If the il-

eum does not fill freely one should operate at once even though the intussusception has apparently been reduced through the ileo cecal valve and the cecum fills without any defect. Little harm is done by a McBurney incision which disposes that the intussusception has been in fact completely reduced and real harm may result if complete reduction of intussusception is incorrectly diagnosed. At times when an intussusception rests entirely within the small bowel it can be demonstrated by barium refluxing through the ileo cecal valve up to the intussusceptum (Fig 10). This is not dependable and in any case one makes no attempt to reduce intussusceptions at this level by barium enema.



Fig 30 (Cont)

C Barium has reached the hepatic flexure between the intussusciptens and the intussusceptum although the latter is still almost at the right vertebral border

D Shows the hepatic flexure filled and barium seeping between the intussusceptum and the larger caliber ascending colon



E Shows free filling of many loops of small bowel. When the barium was expelled the returns were colored pink by blood

F A film taken with the colon less distended after partial expulsion of the barium permits easier differentiation between the large bowel and the small bowel (frame 1 by the partially emptied colon)

The child passed a spontaneous stool and flatus within 6 hours and was discharged well on the 5th day



Fig. 31 Reduction by Barium Enema Alone C. G. Female 6 months old. This child was brought to the hospital 60 hours after the onset of abdominal pain and vomiting. She had been passing bloody mucus for 6 hours before admission. A large tubular mass was felt in the left side of the abdomen and thought to be the intussusception. The child's general condition was good. Administration of intravenous glucose and saline was begun and a barium enema undertaken. A catheter was placed in the stomach as in all these patients to prevent

vomiting and aspiration in the dark of the fluoroscopy room. A balloon catheter was inserted into the rectum and distended.

- A The plain film shows the gastric catheter in place and the rectal balloon inflated. A number of dilated loops of small bowel are seen in the left upper quadrant.
 B Demonstrates the barium outlining the end of the intussusception in the rectum immediately above the balloon although we had not felt the intussusception on rectal examination. (Continued on next page)

Intussusceptions entirely limited to the small bowel will usually present the picture of intestinal obstruction and in such patients if barium enema shows no intussusception in the colon operation should be undertaken at once.

There is great variation in the speed with which reduction can be achieved. In one infant with an intussusception of the transverse colon motion pictures were taken of the entire reduction. The continuous film strip covers a period

of less than five seconds. In another instance an experienced pediatrician called to say he was sending in an infant with intussusception. All was made ready, the baby was met at the door, the intussusception which was encountered at the mid transverse colon was completely reduced in two to three minutes and the baby was on his way to the ward within ten minutes of the time he passed through the hospital gate. At other times reduction may be extremely stubborn

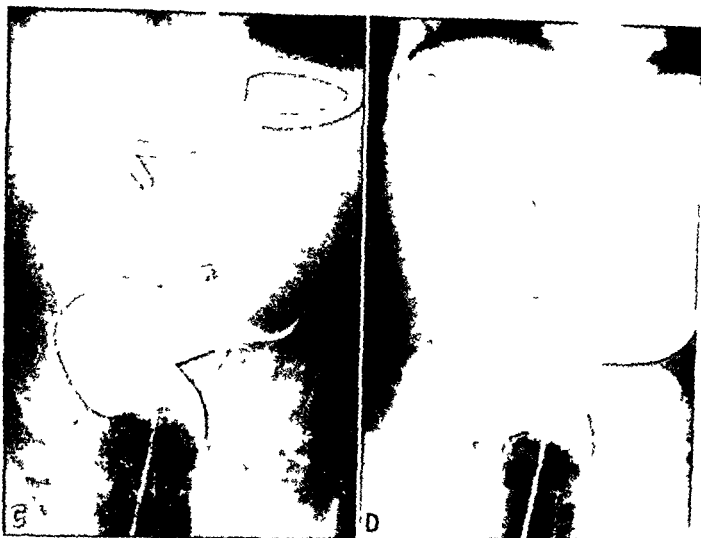


Fig. 11 (Cont.)

C The intussusception has been reduced to the sigmoid and there is a sharp meniscoid edge to the advancing barium column. When the intussusception fits the intussusceptions tightly very little barium is able to ascend between the two loops and one gets a meniscus of this character. When the fit is less snug a good deal of barium may pass between the loops producing the coiled spring appearance as the barium concentrates

between the edematous folds of bowel at the same time that the end of the intussusception produces a large round filling defect. Frequently the meniscoid shadow is seen in the left colon and as the intussusception is reduced the radiologic picture of the intussusception changes toward the right colon.

D The intussusception has been reduced well up into the descending colon. (Continued on next page)

Not rarely there will be a momentary pause when the intussusception is encountered then steady reduction to the splenic flexure. Delay at the splenic flexure may be followed by rapid reduction to the hepatic flexure where there may again be some delay. Filling of the cecum is often slow and the cecum may distend quite markedly before a sudden rush of barium into the small bowel denotes complete reduction.

We have no hesitation in continuing with the

reduction for as long as 15 minutes or an hour so long as steady progress has been made. The children are receiving intravenous fluids or blood as needed during the procedure and the roentgen exposure is only fractional and intermittent. Once it is obvious that there has been an absolute arrest of the barium column for ten minutes or so nothing is to be gained by persisting and operation should be proceeded with.

The principal difficulties in the use of this



Fig 31 (Cont)

- E The reduction has progressed around the bend of the splenic flexure
- F Although the barium has reached the right colon and the filling defect of the original intussusception is still seen in the ascending colon there is an abnormality in

the left transverse colon. Inspection shows the column of barium going through the middle of another intussusceptum and outlining a colo-colic intussusception which is only incompletely reduced

method are likely to involve a leakage of barium from the rectum because of failure to strap the buttocks together tightly or plugging of the tubing or catheter by lumpy barium mixture. If there is any doubt that there has been a free flow of barium into the bowel with maintained pressure the child may be allowed to evacuate and the procedure repeated.

It is our present practice to rely in general upon one continuous sustained injection. The intussusception if not completely reduced is almost invariably reduced to the cecum although in a few cases, it has gone no further than the

ascending colon and in the last case treated the intussusception which proved at operation to be irreducible could not be reduced by the barium enema beyond the hepatic flexure.

It is of the utmost importance to be certain that there is free filling of many loops of small bowel with barium. The distended cecum and the sigmoid if redundant may overlap and between them obscure the field so that it is difficult to see the ileum. In such instances if the child is turned upon the abdomen its own weight may separate these two loops of bowel and permit one to see the ileum between them.



Fig 31 (Cont.)

C This intussusception is still further reduced while the transverse colon is filling and one sees the original intussusception more sharply in the ascending colon. The position of the meniscus of the colo-colic intussusception in F and C is such as to suggest that this second intussusception was actually a retrograde intussusception.



H The colo-colic intussusception is completely reduced and the ascending colon progressively fills with barium.

Under no circumstances do we ever manipulate the abdomen, however great the temptation. Under no circumstances do we raise the criniter of barium higher than three feet six inches above the table. Neglect of these precautions invites rupture of bowel or reduction of gangrenous bowel as a number of reports testify.

If the abdomen becomes so distended with barium that it is difficult or impossible to be certain that loops of small bowel have filled, the catheter is removed, the child allowed to evacuate, and then fluoroscoped once more. The loops of small bowel filled with barium will usually be seen framed by the colon. Immedi-

ately after the completion of the reduction powdered charcoal is deposited in the patient's stomach through the tube already in place. Six hours later an enema is administered to recover the charcoal and prove beyond doubt the relief of obstruction. This method introduced by Hipsley assures one that the obstruction has been relieved but does not necessarily demonstrate that the intussusception has been totally reduced. Hipsley makes use of the observation that fluid which refluxes into the ileum will not be promptly expelled measures the girth of the children before and after a saline enema. If the abdominal girth remains substantially

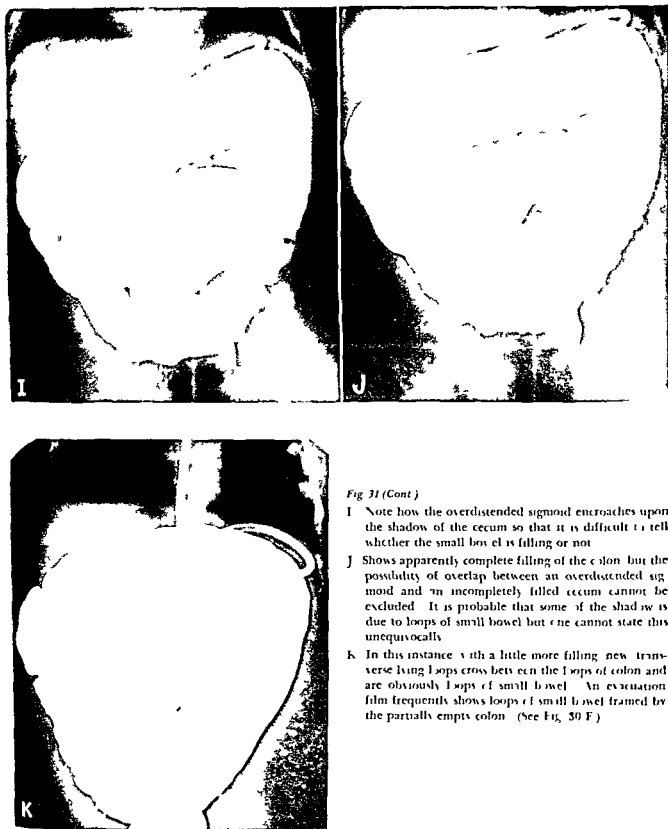


Fig 31 (Cont)

- I Note how the overdistended sigmoid encroaches upon the shadow of the cecum so that it is difficult to tell whether the small bowel is filling or not
- J Shows apparently complete filling of the colon but the possibility of overlap between an overdistended sigmoid and an incompletely filled cecum cannot be excluded. It is probable that some of the shadow is due to loops of small bowel but one cannot state this unequivocally
- K In this instance with a little more filling new transverse lying loops cross between the loops of colon and are obviously loops of small bowel. An evacuation film frequently shows loops of small bowel framed by the partially empty colon. (See Fig 30 F)

increased after expulsion of the enemata accepts this as evidence of free passage of the fluid into the ileum and hence of reduction of the intussusception. While his results have been extraordinarily good we prefer the certainty of direct fluoroscopic observation and the opportunity that this affords for objective documentation on the film of the existence of an intussusception and of its reduction.

The successful reduction of an intussusception is indicated by the following criteria—

1 *The free flow of barium well into the small bowel.* This is the sine qua non of complete reduction and must be insisted upon in all cases which are not to have an immediate operation. The remaining criteria are merely confirmatory.

2 *The return of the barium with feces or with flatus.* This is not helpful in the occasional child who is incompletely obstructed but most children with intussusception are completely obstructed and have emptied the colon distal to the intussusception so that appearance of feces is in them acceptable proof of reduction.

3 *Disappearance of the mass.* At times a mass is still palpable in a child in whom there is positive radiologic evidence of complete reduction of the intussusception. The mass in such cases is the swollen edematous bowel previously forming the intussusception. The enlarged mesenteric lymph nodes which regularly accompany an intussusception may form part of such a palpable post reduction mass. On the other hand a very small intussusception still persisting in the region of the ileocecal valve may no longer be palpable although still present and significant.

4 *Clinical improvement of the child* who often falls into a natural sleep. This is dramatic and fairly constant. As Nordentoft points out incomplete reduction frequently relieves symptoms temporarily so that this sign too is merely confirmatory.

5 *Subsequent recovery in the stool of the charcoal given by mouth or the appearance of a blood free stool.*

Most of the children are so listless and apathetic that the barium enemata seems to cause

them little distress and it is scarcely necessary to restrain them. If restraint is required elastic bandages holding the extended joined hands and the extended feet will decrease the necessity for exposing assistants. In some of the older children it is necessary for properly protected assistants to restrain the hands and feet.

In only a single instance have we had what might be considered an untoward reaction to this treatment. This was in a five month old colored female infant who had been brought to the hospital because of vomiting and a frank upper respiratory infection. However her vom-

Fig 32 (pages 81-82-83) Reduction by Barium Enema Alone. A B Male three years eight months old. This child was seen five hours after the onset of severe abdominal pain. There was a transverse epigastric mass. His condition was good. Barium flowed freely up the descending colon and around the splenic flexure to meet an obstruction in

- A the transverse colon just proximal to the left of the midline
- B The filling defect slowly and progressively moves across the transverse colon to the right of the midline
- C More barium is beginning to pass between the intussusceptum and the intussusciptum. There is a large filling defect in the barium column and the beginning of oval rings of barium in the folds of the edematous intussusceptum
- D & E As the barium reaches the hepatic flexure the fit is much looser and a good deal more barium seeps between the layers of the intussusception producing the striking filling defect and the coiled spring appearance
- F The hepatic flexure is filling more completely but the filling defect persists
- G The right colon and hepatic flexure have filled completely and the filling defect is now visible down in the ascending colon
- H The ascending colon is very largely filled and the out line of the cecum can be seen but it has not filled completely although there is no obvious filling defect
- I The cecum now appears to have filled fairly densely and there is a little barium medial to it which must be in the small bowel
- J With a rich massy loops of small bowel have filled and the cecum appears to have filled completely as well
- K A detail of the small bowel loops shows no abnormality and
- L After withdrawal of the balloon catheter and with expulsion of most of the barium nicely filled loops of small bowel are seen discrete from the large intestine

The child left the hospital well in three days.



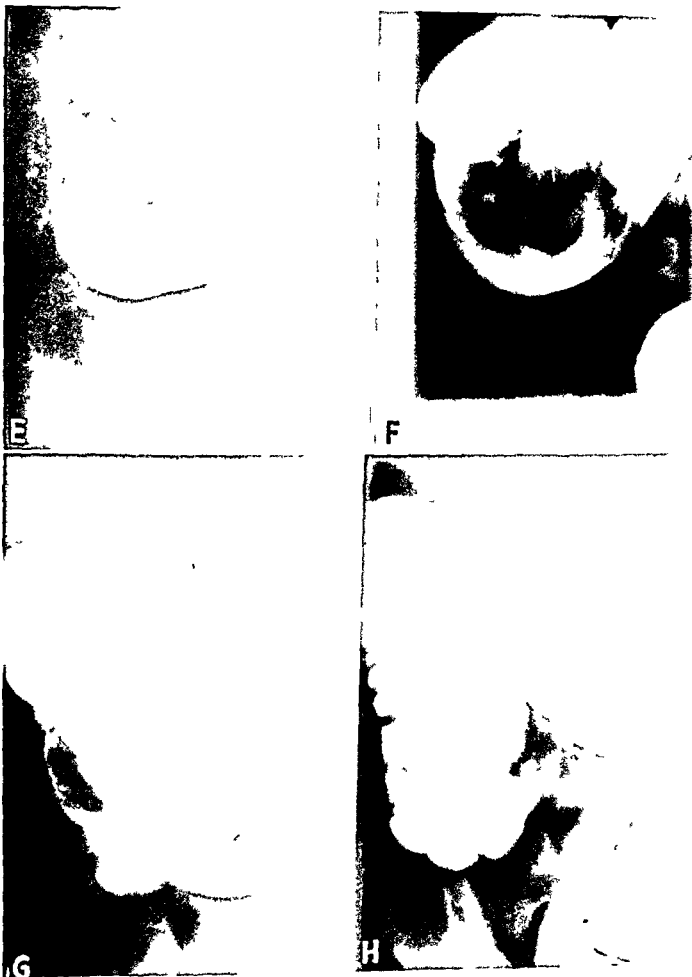
*Fig 3 (Cont)*



Fig 3 (Cont)



Fig 33 Reduction by Barium Enema Alone T W Female 8 months old This child developed diarrhoea and abdominal cramps 18 hours before coming to the hospital began to pass bloody mucus 21 hours before admission to the hospital had vomited two or three times

ing had come on coincidentally with an attack of abdominal pain during which she had drawn her legs up cried and vomited In spite of this vomiting pain and lethargy which was noted in the records she was sent home diagnosed as an acute nutritional disturbance In the two and a half hours which had transpired since the onset of her illness she had not passed blood and actually no blood was passed until she had been home almost ten hours more She was finally brought to the hospital 52 hours after the onset of the illness when she was prostrated dehydrated and had an easily palpa-

ble mass in the left lower quadrant The barium enema encountered the intussusception in the descending colon (Fig 11) whence it was easily reduced to the splenic flexure in a period of five minutes and to the hepatic flexure in another ten minutes There was then no change for 30 minutes of steady pressure It is quite obvious that at this point the child should have been taken to the operating room However two subsequent and fairly deliberate attempts were made at reduction by barium enema and on the third trial some barium was seen to pass into the ascending colon and cecum Since it

on the first day of symptoms but had taken and retained some feedings She was apathetic quiet and prostrated The abdomen was relaxed There was a fullness in the lower abdomen and there was an easily palpable curved firm and movable mass extending from the umbilicus into

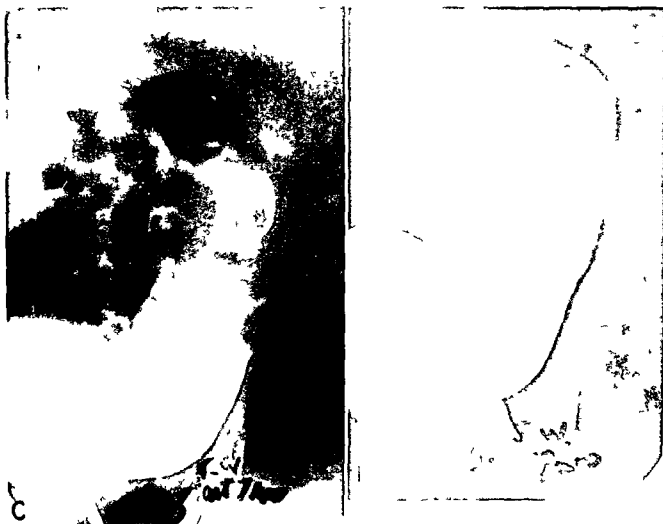


Fig 33 (Cont)

the left lower quadrant and easily palpable rectally as well. Barium enema at once showed an intussusception in the rectum. As seen in A the intussusceptum reached low into the rectum. Barium has begun to pass between

the intussusceptum and intussusciptum. The outline of the distended rectal balloon is sharply visible. In B the concave meniscus of barium is seen to have reached the sigmoid and in C the ascending colon. In both D and

did not fill the ileum the child was ordered to the operating room. Before she could get there she developed generalized tonic and clonic convulsions and had two subsequent seizures of the same type. The operation was postponed for several hours on this account but when it was finally undertaken the intussusception was found completely reduced. The child very slowly recovered from the effects of these convulsions the cause and nature of which remained uncertain.

Results

In the 77 intussusceptions treated by barium enema 53 have been reduced by the barium

enema alone in incidence of 69% (11, 28). Of the 24 patients who were operated upon there were five in which the reduction had been achieved by the barium enema so that the operation was merely confirmatory. The barium enema therefore completely reduced the intussusception in 58 of the 77 cases or 75%. There have been no deaths.

Recurrence

We have had three recurrences in the 77 cases. The first recurrence was in a 13 month old colored male first seen two weeks after the onset of abdominal pain and vomiting with constipation, anorexia and cramps. He had cran-



Fig 3 (Cont.)

E a little barium has passed between the intussusceptum

berry colored stools was moderately prostrated markedly dehydrated and had a large mass in the epigastrium. The barium enema encountered the distal end of the intussusception at the splenic flexure whence it was promptly reduced into the ileum which filled well. Charcoal given by stomach tube was recovered five hours later in a spontaneous stool and the following morning he passed a normal stool felt well had no palpable mass. He then remained asymptomatic until 18 hours after the enema reduction when he vomited twice and shortly after passed a curdy jelly stool and had a doughy mass palpable in the left lower quadrant extending up to the left upper quadrant and across the midline. By barium enema the intussusception was once more reduced with fill-

ing and intussuscipiens to outline the splenic flexure. In F the splenic flexure fills progressively

ing of the ileum although there remained a full inch defect in the cecum. Operation disclosed an intussusception of the appendix itself (see Fig 8). It seems possible that the intussusception of the appendix persisted after the first reduction but had not been observed fluoroscopically as it had in the second reduction. The child remained well after resection of the appendix and part of the cecum.

The second recurrence was in a child of seventeen months in whom an intussusception had previously been reduced by barium enema 15 months before when she was two months old. The second intussusception was similarly uneventfully reduced by barium enema.

The third recurrence was in a child who had an intussusception of six hours which was en-

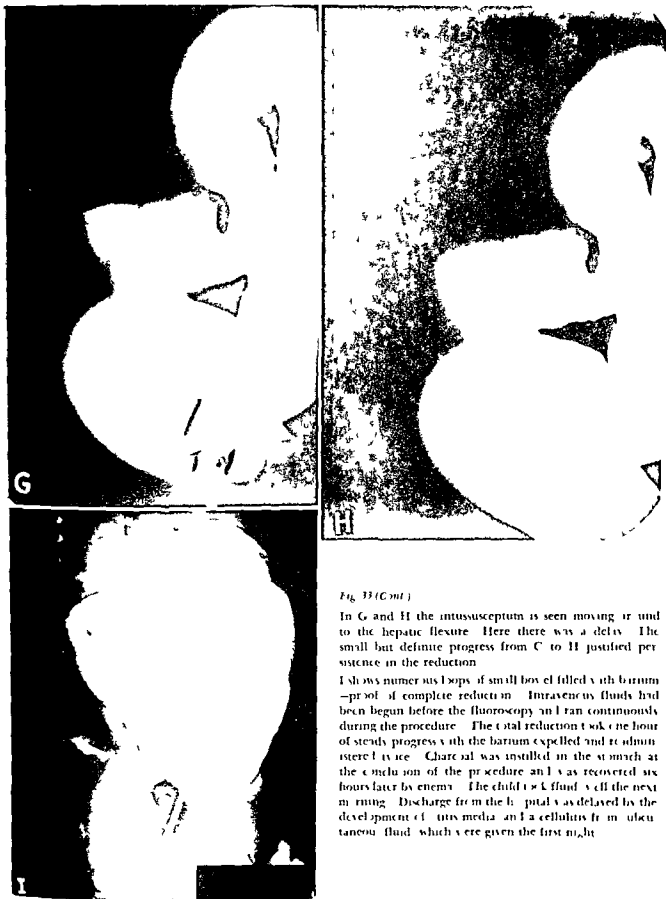


Fig. 33 (Cont.)

In G and H the intussusceptum is seen moving upward to the hepatic flexure. Here there was a delay. The small but definite progress from C to H justified persistence in the reduction.

I shows numerous loops of small bowel filled with barium—proof of complete reduction. Intravenous fluids had been begun before the fluoroscopy and ran continuously during the procedure. The total reduction took one hour of steady progress with the barium expelled and readministered twice. Charcoal was instilled in the stomach at the conclusion of the procedure and was recovered six hours later by enema. The child took fluids well the next morning. Discharge from the hospital was delayed by the development of cellulitis and a cellulitis from abdominal fluid, which were given the first antibiotic.

countered at the mid transverse colon and readily reduced into the small bowel. Charcoal administered through a stomach tube was recovered by enema some hours later and the child had normal stools and began taking fluids. Sixty hours later she developed cramps and began vomiting again. Another intussusception was found and this time the intussusception was reduced to the ileum but the ileum itself could not be filled. The abdomen was explored and the intussusception found actually to have been completely reduced. The appendix was removed. The child has had no subsequent difficulty.

Confirmatory Operation

There were four other patients in whom operation undertaken after an apparently incomplete reduction by barium enema served simply to prove that the intussusception had indeed been completely reduced. The second such confirmatory operation was undertaken in a two and a half year old white girl admitted to the hospital with a ten day history of abdominal cramps and restlessness with frequent vomiting and only occasional retention of feedings. She was prostrated quite markedly dehydrated, acidotic and there was a palpable mass in the right upper quadrant. A barium enema encountered in intussusception at the hepatic flexure. This case was treated in 1912 when we assumed that a

(Text continues on page 100)



Fig 31 Reduction by Barium Enema Alone. C. E. Female 4 months old. This child was seen 151 hours after the onset of symptoms marked by vomiting followed by evidences of abdominal pain. She had been given castor oil and 5 hours after the onset of symptoms passed blood with a stool. She had been lethargic all day before the onset of frank symptoms. The abdomen was soft, there was some tenderness and resistance in the left lower quadrant where the mass could be felt quite readily. The mass was easily palpable on rectal examination as well. Intravenous fluids were administered through a catheter cut-down.

A Shows the characteristic meniscus of the advancing barium column already displaced past the splenic flexure. The intussusception reduced so quickly that although the flow of barium was cut at once when the intussusception was outlined in the rectum, the reduction proceeded to the splenic flexure before a film could be taken.

B Shows the reduction progressed into the mid transverse colon with a filling defect in the lumen caused by the head of the intussusception.



C Shows the filling defect even more plainly in the right side of the transverse colon



D Shows the barium filling the ascending colon



E. One can see incomplete filling of the cecum at the same time that the appendix is nicely outlined. Reduction to this point had been extremely rapid but at this point barium began to escape from the rectum. The catheter was withdrawn, the child allowed to expel the barium, the catheter reinserted, strapped in place, and the flow of barium resumed.



F Shows the filling of the many loops of small bowel which occurred with dramatic rapidity. It is possible for the abdomen to be completely flanked out by overlapping of a distended sigmoid and a distended right colon without filling of loops of small bowel. For this reason the barium was evacuated through the catheter.



G Many loops of small bowel are quite distinctly visible.
H The catheter was removed and after further evacuation there is no question of the adequacy of the reduction.

Note the gastric tube visible in A-F. In all cases the stomach is emptied before the manipulation is begun.

Charcoal was deposited through this tube and appeared in a spontaneous stool five hours later. The child fell asleep at the conclusion of the procedure but when awakened was a good deal more alert than previously. A mild phlebitis at the site of her cut down kept her in the hospital for 6 days.

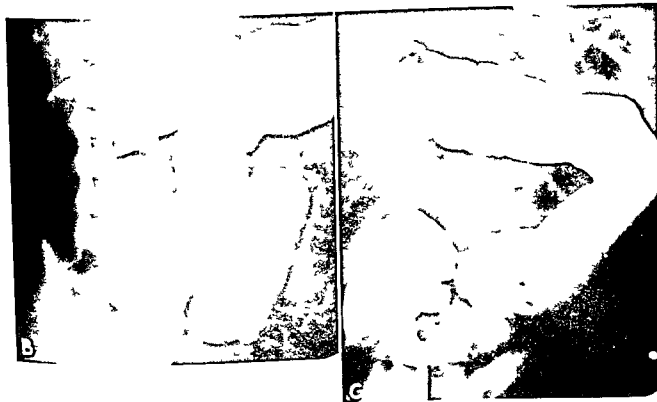
Fig 3. Reduction by Barium Enema Alone. R. I. Female, 8 months old. This child had had diarrhoea for 24 hours which had ceased about 8 hours before admission to the hospital. She had been vomiting for 3 hours before admission. The child was not particularly ill; the abdomen was soft; a tubular mass was easily felt lying transversely above the umbilicus. On barium enema the intussusception was encountered at the mid transverse colon. Reduction proceeded rapidly to the mid ascending colon when the catheter was expelled. On the second attempt the reduction proceeded to the cecum when the catheter was expelled. On the third attempt the small bowel filled freely. These maneuvers required an hour

and a half. The child was lethargic on admission and during the procedure became normally reactive and cranky and the previously found mass was no longer palpable. The child was in the hospital for 31 days.

A Shows the intussusception encountered in the transverse colon immediately to the left of the vertebral column. The meniscoid edge of the advancing barium column is plainly seen.

B An oblique view a few moments later shows the mid transverse colon with a sharp and clear meniscus.

C Shows the barium seeping around the intussusception at the hepatic flexure.



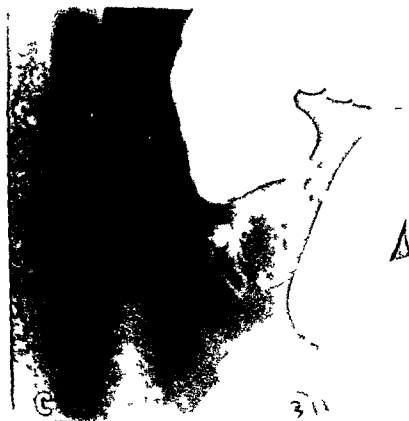
(Continued on next page)



Fig 37 Reduction by Barium Enema Alone. H. F. Male 8 years old. This boy came to the hospital (Mt S. H.) 46 hours after the onset of intermittent colicky abdominal pain. He was known to have cystic fibrosis of the pancreas. He had not vomited and had not passed blood. His general condition was good and an easily palpable rounded soft mass was felt in the right lower quadrant. We were called in consultation on this patient because a barium enema had demonstrated the intussusception and had reduced it from the transverse colon to the cecum but no further and the attempt had been abandoned and operation was contemplated. Examination showed the patient still in good condition with an easily palpable mass in the right lower quadrant. The catheter was reinserted and strapped in place and barium

allowed to flow uninterruptedly from a height of 5 feet above the operating table without any manipulation of the barium or of the abdominal wall.

- A. The intussusception had progressed once more and was now encountered just beyond the hepatic flexure producing the typical filling defect in the barium column. Note the apparent double meniscus showing that the meniscoid pattern is caused in part by the protrusion of the intussusceptum into the intussusciens and in part by barium filling the edematous folds of the intussusceptum.
- B. Reduction proceeded rapidly to the ascending colon which filled well.
- C. The cecum filled poorly as it had originally and an irregular filling defect appeared.





D. As the barium was allowed to flow, the cecum progressively filled with barium.

Although there is still an obvious filling defect in the cecum there is at least one transverse lying loop of what must be ileum filled with barium. It is important to continue the flow of barium at this point. A false diagnosis of reduction may be made if a little barium slips into the ileum past an incompletely reduced intussusception.

E. Shows complete filling of the cecum and of many loops of small bowel. The abdomen had filled so completely with barium before this film had been taken that it had not been possible to be certain that the opacity was caused by small bowel. This film taken after evacuation of some of the barium shows free filling of many loops of small bowel.

Six days later a repeat barium enema was performed because in children of this age causative lesions are more commonly found than in infants. No such lesion was demonstrated.





Fig 38 Reduction by Barium Enema Alone D B Female 8 months old This patient was admitted to the hospital 24 hours after the onset of vomiting Her mother stated that the child was constipated and seemed to be having abdominal pain The child had had an upper respiratory infection for several days She was extremely prostrated and dehydrated and passing bloody mucus per rectum There was resistance in the right upper quad-

rant where a mass was thought to be palpable On barium enema the intussusception was encountered on the left side of the transverse colon and was rapidly and completely reduced with free filling of the small bowel

A Shows the typical meniscus encountered in the transverse colon just to the left of the vertebral column

P The intussusceptum has been reduced a little blunt ing the horns of the meniscus



C The intussusception is found to be reduced to the hepatic flexure. Here as the bowel becomes of larger caliber and there is more space between the intussusceptum and the intussusciens we begin to see numerous coil like shadows of barium passing between the



intussusceptum and the intussusciens.
D Numerous loops of small bowel are seen to have filled and the colon is completely outlined and filled. The child left the hospital well on the 5th day.



Fig 39 Reduction by Barium Enema Alone B A Female 7 months old This infant was seen 3 hours after she awakened screaming with pain and doubling up her thighs A few moments later she had a normal bowel evacuation and began to vomit The paroxysms of pain and vomiting recurred at 10 to 15 minute intervals She was lethargic but not shocked There was a firm sausage shaped mass lying transversely across the abdomen just above the umbilicus The intussusception was reduced by barium enema in a matter of seconds In order to obtain the roentgenograms the flow of barium was momentarily interrupted for each exposure Charcoal deposited in the stomach appeared in a spontaneous stool

5 hours later Feedings were started the next morning and the child discharged in 6 days The intussusception was encountered at the splenic flexure where there is visible in

A The large filling defect caused by the intussusception and the long horns of the meniscus as the barium slips between the inner and outer coils preparatory to reducing the intussusception

B Shows filling of the colon and many loops of small bowel The pattern of the barium in the mid transverse colon is suggestive of a second colo-colic intussusception apparently retrograde but may be due to persistent edema The child had no further difficulty

chronic intussusception of this duration would not yield to a barium enema and the barium enema which was undertaken was meant to be purely diagnostic. It was undertaken by the radiologists who said that there was no tendency for the intussusception to reduce. Operation was proceeded with although the mass seemed less definite than it had before. At operation there was no intussusception but the entire ascending colon and an inch or two of the terminal ileum were edematous, thickened and covered with fibrin. The child had no subsequent difficulty.

The third purely confirmatory operation was performed in a ten month old white male who was seen 12 hours after the onset of bloody rectal discharge and abdominal pain. He had a mass in the right mid abdomen and barium enema showed the intussusception in the mid transverse colon. The cecum did not appear to fill although the intussusception was at least partially reduced and operation was undertaken. With the abdomen open there was seen only edematous and injected terminal ileum and cecum with no remaining intussusception.

The fourth confirmatory reduction was in a child of six months who had come to the hospital twelve hours after he had suddenly begun to scream with pain. He was passing bloody rectal discharge and had a sausage shaped mass lying transversely in the epigastrium. On barium enema (Fig 10) the intussusception was first localized distal to the splenic flexure in the upper part of the descending colon. It was slowly reduced through the splenic flexure, transverse colon, hepatic flexure and ascending colon to the cecum. The terminal ileum was then visualized lying to the right of the cecum and filled for four inches only. For this reason operation was undertaken but the intussusception was found to be completely reduced, the bowel being simply somewhat edematous.

The last merely confirmatory operation was that performed on the five month old child previously mentioned because of the convulsions occurring after the barium enema reduction

(Fig 41). Again in this instance the terminal ileum was seen to fill only for four inches and operation was undertaken on the suspicion that the intussusception had not been completely reduced. At operation the intussusception was found to have been completely reduced and the appendix was removed.

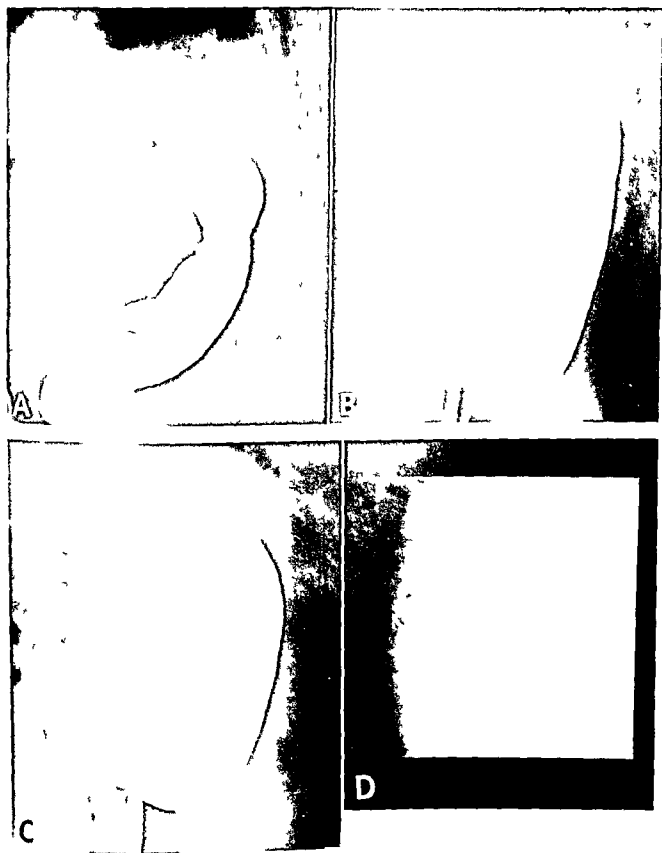
Completion of Reduction by Operation

The wisdom of the exploratory operations performed in the last two cases because of incomplete filling of the ileum is demonstrated by another patient, one of the two in whom an incorrect diagnosis of complete reduction was made. This was a four year old girl with a 24 hour intussusception which was encountered at the hepatic flexure and reduced into the terminal ileum. It was noted that only six or seven inches of the terminal ileum filled but the child was allowed to return to the ward. She began to vomit again several hours later. A mass was once more palpable and it was again demonstrated on barium enema to be an intussusception. It was reduced to the cecum but no further. Operation was undertaken and after the remainder of the intussusception had been reduced manually there was disclosed a Meckel's diverticulum 15 inches proximal to the ileocecal valve. The Meckel's diverticulum was resected and the child did well.

→

Fig 10 Operative Confirmation of Complete Reduction by Barium Enema. W C 6 months old. This child came to the hospital 12 hours after he had suddenly begun to scream with pain. He was passing a bloody rectal discharge and had a sausage shaped mass lying transversely in the epigastrium. He was knocked out and dehydrated and at the same time restless. The abdomen was scaphoid and completely relaxed. The sausage shaped mass was easily felt lying transversely above the umbilicus. There was dark blood in the rectum. Barium enema was undertaken at once.

- A The intussusception was met just distal to the splenic flexure in the upper part of the descending colon. It was slowly and progressively displaced proximally.
- B & C. Show the splenic flexure filled and the meniscus advancing into the transverse colon.
- D The meniscus has flattened out as the intussusception has been still further reduced across the transverse colon.





- I F K C Show the progressive filling of the transverse colon and hepatic flexure
- II Shows a sudden filling of the ascending colon with barium beginning to outline the filling defect in the cecum
- J Shows the cecum very largely filled and with no sharp filling defect in the wall of the cecum but the terminal ileum has not filled

J Shows a loop of terminal ileum quite clearly filled and lying lateral to the colon—a not uncommon location for the terminal ileum. There is actually visible a concave edge to the upper end of the barium column and this was correctly interpreted as a meniscus indicating incomplete reduction.

(Continued on next page)



through McBurney incision the cecum was found to be edematous and the small bowel to be essentially normal with no intussusception present. The appendix was removed and the child left the hospital well on the tenth day. The child had a *blind course* and there is no indication in the record of the reason for the long hospitalization. Whenever there is doubt as to the completeness of reduction or whenever is in this case barium is clearly seen to enter the small bowel and then to delay operation should be undertaken. Under no circumstances should the child be given a trial by labor and allowed to demonstrate clinically whether reduction has been complete or not. We much prefer to operate and find the intussusception reduced rather than to delay and run the risk that an intussusception has been incompletely reduced. A small McBurney incision allows for adequate exploration of the terminal ileum, reduction of the persisting portion of the intussusception if one is found, and removal of the appendix.



Although the procedure had required one and a half hours' progress had been steady and the child's condition was excellent. Because one cannot depend upon reducing intussusceptions which have demonstrably begun well proximal to the ileocecal valve, it has been our practice to abandon hydrostatic pressure and resort at once to operation whenever there is an obvious delay in the terminal ileum, as was evidenced in this case. In accordance with that practice this child was taken to the operating room. At operation



Fig. 41 Operative Confirmation of Complete Reduction by Barium Enema. C A Female 5 months of age. This child's treatment represented unwise and stubborn persistence in use of the barium enema which we feel to have been quite improper despite the ultimately successful outcome. The child was seen in the Outpatient Department two hours after the onset of abdominal pain which caused her to draw her legs up with each spasm. She had vomited several times and had an obvious upper respiratory infection. She was sent home diagnosed as an acute nutritional disturbance and instructed to return the next day. The child was not brought back until two days later. 52 hours after the onset of her symptoms. In the meantime she had been vomiting repeatedly and had become lethargic and had passed bloody material from her rectum. She was prostrated and dehydrated and a mass measuring 1×1 centimeters was easily felt in the left lower quadrant. In the rectum there was

a current jelly stool. A barium enema was begun shortly after the child was admitted to the hospital and it was recorded in the chart that the intussusception encountered in the descending colon was easily reduced to the splenic flexure in five minutes and to the hepatic flexure in ten minutes where there was no change for the next thirty minutes. A second trial was made after the child was given a brief rest and in twenty five minutes again no progress was made. A third trial was made at once and this time after fifteen minutes some barium was seen in the ascending colon and cecum. No further progress being made after another thirty minutes the effort was abandoned and the child was dispatched to the operating room. A. Numerous dilated loops in the plain film of x-rays indicate an intestinal obstruction of some character. None of the dilated loops are identifiable as colon.

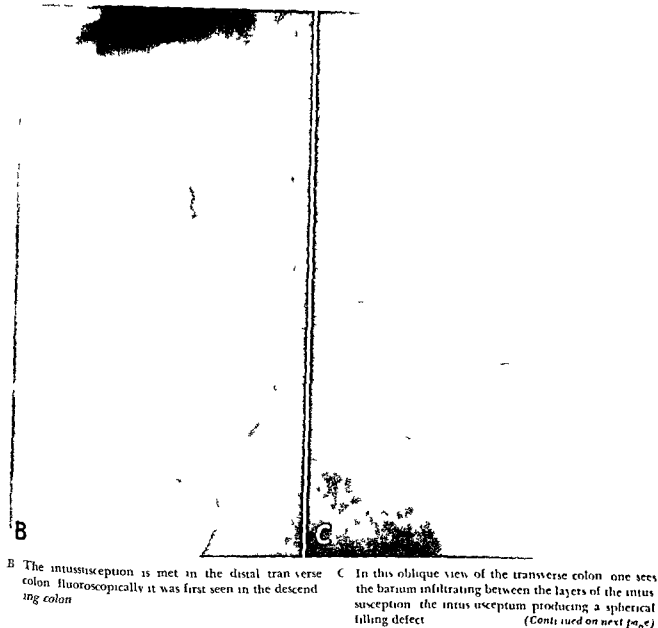
(Continued on next page)

It may be of interest to see the status of the intussusception at operation in the other cases incompletely reduced by the barium enema.

2. In a six month old male infant an intussusception of 30 hours was encountered at the hepatic flexure and reduced by barium enema to

the cecum. The appendix filled but only a little barium entered the ileum (Fig. 12). Through a McBurney incision a small stub of ileum was removed from the cecum and the appendix removed.

3. In a seven month old male an intusus



B The intussusception is met in the distal transverse colon. Fluoroscopically it was first seen in the descending colon.

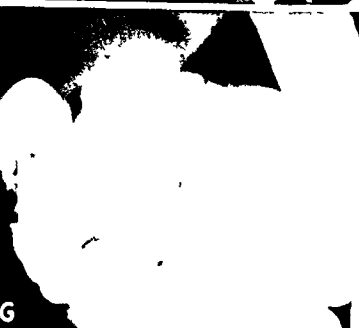
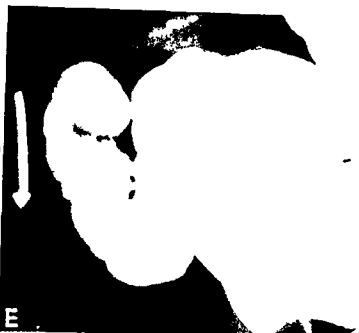
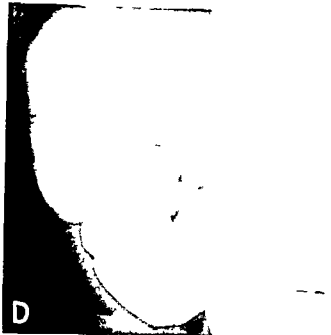
C In this oblique view of the transverse colon one sees the barium infiltrating between the layers of the intussusception, the intussusceptum producing a spherical filling defect.
(Continued on next page)

ception of 27 hours was encountered distal to the splenic flexure. The cecum filled but the ileum did not. Eight hours later cramps recurred and on a repeat enema the cecum began to fill but the ileum did not. This was the seventh case in our barium enema series, our only other mistaken diagnosis of complete reduction and was one of those which convinced us that operation must be undertaken at once if the ileum fails to fill freely. At operation an ileoileal intussusception which had passed into the cecum was found and reduced; the leading point of the intussusception 12 centimeters from

the ileocecal valve was cyanotic and a segment two or three centimeters in length was resected and an anastomosis performed. Microscopic studies showed this to be perfectly viable bowel (Plate IID). The child did well.

4 In a child of eight months an intussusception of eight hours was encountered on barium enema at the splenic flexure and was reduced to the ileocecal valve without filling of the ileum. At operation about one inch of ileum was gently pressed out of the cecum through a McBurney incision.

5 In a six-month-old infant with an intus-



D Shows the intussusception nearing the hepatic flexure and
 E Shows the hepatic flexure filled
 F Shows the barium passing down into the ascending colon and the cecum and
 G One sees the cecum still further filled. This is the last film which was taken. There is a suggestion in the middle of the field of loops of small bowel which have been filled even though there is still a filling defect in the cecum.

Before she could get to the operating room the child had the first of three severe generalized tonic and clonic convulsions which delayed operation for a period of several hours. When operation was finally undertaken the intussusception was found to have been completely reduced either by the Enema or subsequent to that. Eighteen inches of distal ileum, the cecum and the proximal ascending colon were engorged with blood, edematous

and swollen and had obviously been included in the intussusception. There were numerous enlarged succulent lymph nodes in the neighborhood of the ileocecal valve. The child did not awaken for nine hours after anesthesia but thereafter made a good recovery and was taking fluids by mouth on the third day. She was discharged well on the fifteenth day. The initial error in the diagnosis was the result of an inadequately high index of suspicion. The only deaths from intussusception in the Johns Hopkins Hospital in the last 19 years (the last one 12 years ago) were in children in whom the diagnosis had been similarly missed at the hospital. In the present instance the child's life was probably saved in spite of the over vigorous and persistent attempts at reduction because intravenous fluid administration had been begun even before reduction had been attempted and because reduction having finally been achieved resuscitation was not delayed.

(Continued from the top)



Fig 4 Operative Completion of Incomplete Reduction by Barium Enema. **A** Male 6 1/2 months old. This child came to the hospital 30 hours after the onset of irritability, abdominal pain and vomiting. He first passed bloody clots following a rectal examination in the hospital but had been vomiting up to the time of admission although he had been able to take a little water. There was slight resistance in the right upper quadrant but no mass could definitely be felt. Upon barium enema fluoroscopy the intussusception was encountered with its apex at the hepatic flexure. It was readily reduced to the cecum and could not apparently be reduced further. The barium was observed to pass freely into the appendix and some barium passed into the ileum but the ileum did not

fill fully and a mass was now palpable in the region of the cecum for the first time. At operation through a right McBurney incision a small nubbins of ileum was found protruding into the cecum and was easily reduced. An appendectomy was performed and the child left the hospital well on the 8th day.

A Shows the filling defect of the barium column just to the left of the hepatic flexure with the characteristic meniscus and oval filling defect.

B The intussusception has been further reduced toward the hepatic flexure. One can see a few rings of barium around the negative shadow of the intussusceptum as the barium seeps between the intussusceptum and the intussusciptum.

(Continued on next page)

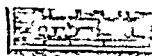
susception of 28 hours duration an intussusception filling the ascending colon was rapidly and almost instantaneously reduced to the cecum but without filling of the small bowel. At operation a nubbins of ileum was reduced through the ileo cecal valve and the appendix removed.

6 In a male of three months an intussusception of over 96 hours duration was encountered in mid sigmoid and reduced to the ascending colon with the barium enema. At operation

with some difficulty the reduction was completed. This child did well but returned three months later and was operated upon for acute mechanical intestinal obstruction due to adhesions and had one further bout of obstruction a month later which was treated without operation. The note was made at the original operation that the muscularis and serosa of the ascending colon were badly damaged although the bowel was considered viable as it in fact proved to be

required. One is justified in maintaining hydrostatic pressure upon the bowel as long as there is persistent and steady reduction of the intussusception, slow though it may be. If no progress made the patient should be sent to the operating room which has been held in readiness.

Stubborn determination to achieve a cure by barium enema has no place in a rational therapeutic policy. This is the only instance in which we have seen a resolution in association with intussusception reduced by barium enema.



C

C Shows the intussusception reduced to the ascending colon with a good deal of barium passing now between the intussusceptum and the loosely fitting intussusciens

D The final film there is seen some barium in the appendix and some in the terminal ileum but an obvious persistent filling defect in the cecum. The



D

apparent filling defect high in the ascending colon is of course a peristaltic wave

As in this case operation must be undertaken promptly unless there is free filling of the ileum with barium and without any persistent deformity of the cecum (From Ravuch and McCune *Ann Surg* 18 1918)

None of the children who have had reduction of intussusception by barium enema alone have had subsequent attacks of mechanical intestinal obstruction and this is the only one of the children with reduction completed by operation who had such intestinal obstruction

7 This thirteen month old male is mentioned under recurrence of intussusception after barium enema reduction. An intussusception of 11 days duration with a typical history was encountered at the splenic flexure. It was reduced to the cecum and the small bowel could be seen filling well. Charcoal given by stomach tube was passed by rectum five hours later.

The child had normal stools, appeared perfectly well without a palpable mass and was asymptomatic until 18 hours after the reduction when the symptoms of intussusception recurred. There was a mass in the left lower quadrant. The intussusception was reduced from the descending colon or sigmoid to the cecum where a small filling defect remained. At operation the only intussusception remaining was found to be that of the appendix which was removed together with its base of cecal wall. The child did well.

8 In a 13 month old male an intussusception of 27 hours duration was encountered on barium

enema in the left transverse colon and reduced through the cecum up into the ileum. Six inches of ileum filled and then a typical effect could be seen in the ileum. At operation through a McBurney incision a small ileal intussusception was reduced without difficulty and the appendix was removed.

9 An intussusception of 53 days duration in an eight month old child was reduced from the splenic flexure to the cecum. At operation the button of ileum in the cecum was flicked out.

10 An intussusception of 12 hours duration in an 11 month old female was encountered on the left side of the transverse colon and reduced to the cecum (Fig 43). At operation the nubbin of ileum was easily popped back into the bowel and the appendix removed.

11 In a 29 month old female in profound apathy with an 18 hour intussusception, barium enema rapidly reduced the intussusception from the midtransverse colon to the cecum. The small bowel did not fill readily. At operation 14 inches more of intussusception was exposed disclosing a Meckel's diverticulum which was resected.

12 An intussusception of 28 hours in an eight month old child was reduced from the sigmoid to the ascending colon. At operation the remainder of the intussusception was readily reduced.

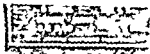
13 This was a four year old child with a 57 hour old intussusception presenting in the left transverse colon. The cecum did not fill completely and at operation the tiny remaining portion of the intussusception at the ileo cecal valve reduced just as it was being demonstrated with a sponge stick in the abdomen.

14 In a child of 15 months a 46 hour old intussusception presenting at the recto sigmoid was reduced to the cecum in 30 minutes of steady progress. The ileum did not fill. At operation the last bit of the intussusception was flicked out of the cecum and the appendix was removed.

15 In a seven year old boy with a five hour intussusception reaching the hepatic flexure the barium enema reduced the intussusception to the cecum but no further. At operation twelve

inches of intussusception was reduced. This was followed by a 24 hour intussusception which reduced the splenic flexure to the hepatic flexure in 30 minutes (Fig. 27) but could not be further reduced. Operation was undertaken at once the bowel deflated reduction and a resection and primary end to end anastomosis was performed. The child left the hospital well in ten days. No primary lesion was found in the bowel.

In an additional case listed as requiring operation in addition to the barium enema an intussusception of only five hours duration in a boy two years and four months old was encountered in the mid transverse colon and completely and readily reduced by the barium enema. The barium entered the small bowel freely the mass was no longer palpable and within six hours the child passed charcoal and stool. He seemed quite well. Six and a half hours after reduction he developed cramplike abdominal pain and began to pass blood and mucus together with stool. No mass reappeared until after 24 hours when a vague mass was felt and it was thought that he had a recurrence. At operation the terminal ileum for three or four inches and the cecum and proximal ascending colon were tremendously thickened and indurated and it was



C

C Shows the intussusception reduced to the ascending colon with a good deal of barium passing now between the intussusceptum and the loosely fitting intussusciptens

D The final film there is seen some barium in the appendix and some in the terminal ileum but an obvious persistent filling defect in the cecum. The



D

apparent filling defect high in the ascending colon is of course a peristaltic wave

As in this case operation must be undertaken promptly unless there is free filling of the ileum with barium and without any persistent deformity of the cecum (From Rivitch and McCune *Ann Surg* 128 1918)

None of the children who have had reduction of intussusception by barium enema alone have had subsequent attacks of mechanical intestinal obstruction and this is the only one of the children with reduction completed by operation who had such intestinal obstruction

7 This thirteen month old male is mentioned under recurrence of intussusception after barium enema reduction. An intussusception of 11 days duration with a typical history was encountered at the splenic flexure. It was reduced to the cecum and the small bowel could be seen filling well. Charcoal given by stomach tube was passed by rectum five hours later.

The child had normal stools, appeared perfectly well without a palpable mass and was asymptomatic until 18 hours after the reduction when the symptoms of intussusception recurred. There was a mass in the left lower quadrant. The intussusception was reduced from the descending colon or sigmoid to the cecum where a small filling defect remained. At operation the only intussusception remaining was found to be that of the appendix which was removed together with its base of cecal wall. The child did well.

8 In a 13 month old male an intussusception of 27 hours duration was encountered on barium

enema in the left transverse colon and reduced through the cecum up into the ileum. Several inches of ileum filled and then a typical filling effect could be seen in the ileum. At operation through a McBurney incision a small ileoileal intussusception was reduced without difficulty and the appendix was removed.

9 An intussusception of 53 days duration in an eight month old child was reduced from the splenic flexure to the cecum. At operation a button of ileum in the cecum was flicked out in an 11 month old female was encountered in the left side of the transverse colon and reduced to the cecum (Fig 43). At operation a small nubbin of ileum was easily popped back into the bowel and the appendix removed.

10 An intussusception of 12 hours duration in an 11 month old female in profound apathy with an 18 hour intussusception barium enema rapidly reduced the intussusception from the midtransverse colon to the cecum. The small bowel did not fill readily. At operation 14 inches more of intussusception was reduced disclosing a Meckel's diverticulum which was resected.

11 In a 29 month old female in profound apathy with an 18 hour intussusception barium enema rapidly reduced the intussusception from the midtransverse colon to the cecum. The small bowel did not fill readily. At operation 14 inches more of intussusception was reduced disclosing a Meckel's diverticulum which was resected.

12 An intussusception of 28 hours in an eight month old child was reduced from the sigmoid to the ascending colon. At operation the remainder of the intussusception was readily reduced.

13 This was a four year old child with a 57 hour old intussusception presenting in the left transverse colon. The cecum did not fill completely and at operation the tiny remaining portion of the intussusception at the ileo cecal valve reduced just as it was being demonstrated with a sponge stuck in the abdomen.

14 In a child of 15 months a 46 hour old intussusception presenting at the recto sigmoid was reduced to the cecum in 30 minutes of steady progress. The ileum did not fill. At operation the last bit of the intussusception was flicked out of the cecum and the appendix was removed.

15 In a seven year old boy with a five hour intussusception reaching the hepatic flexure the barium enema reduced the intussusception to the cecum but no further. At operation twelve

inches of ileum was reduced and the appendix removed.

16 In a three and a half year old boy with a 14 hour intussusception at the hepatic flexure the intussusception was reduced into the ileum which failed to fill freely. At operation the intussusception was found to extend far proximally into the ileum and to have arisen in a large lymphoid patch about three feet proximal to the ileocecal valve. Reduction was easily accomplished and the appendix removed.

17 In a three year old boy an intussusception of six hours duration had reached the left side of the transverse colon. The barium enema reduced it quickly to the cecum. The ileum did not fill. At operation a button of ileum in the cecum was readily pushed back with the thumb and forefinger.

18 In only a single case was the intussusception irreducible and bowel resected. This was in a five month old female with a 24 hour intussusception which had reached the splenic flexure. It was reduced to the hepatic flexure in 30 minutes by barium enema (Fig 27) but could not be further reduced. Operation was undertaken at once the bowel defied reduction and a resection and primary end to end anastomosis was performed. The child left the hospital well in ten days. No primary lesion was found in the bowel.

In an additional case listed as requiring operation in addition to the barium enema an intussusception of only five hours duration in a boy two years and four months old was encountered in the mid transverse colon and completely and readily reduced by the barium enema. The barium entered the small bowel freely the mucus was no longer palpable and within six hours the child passed charcoal and stool. He seemed quite well. Six and a half hours after reduction he developed cramplike abdominal pain and began to pass blood and mucus together with stool. No mass reappeared until after 21 hours when a vague mass was felt and it was thought that he had a recurrence. At operation the terminal ileum for three or four inches and the cecum and proximal ascending colon were tremendously thickened and indurated and it was



Fig 13 Operative Completion of Incomplete Reduction by Barium Enema I G Female 11 months old This child was seen 12 hours after the onset of spasms of periodic abdominal pain She vomited immediately after the onset and repeatedly thereafter She took feedings when offered but was unable to retain them She was a

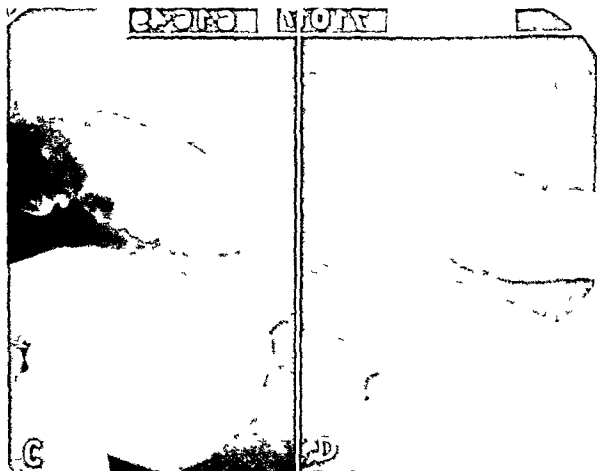
well nourished child in good condition The abdomen was very soft and relaxed There was an easily visible and palpable sausage shaped mass in the right upper quadrant four by three centimeters in diameter There was a little tenderness over the mass

(Continued on next page)

thought that it might be the site of a tumor perhaps a lymphosarcoma For this reason the terminal ileum and the right colon were resected and an anastomosis performed Plate IIC of the specimen shows merely the changes consistent with viable bowel at this period after reduction of an intussusception The child did well although he returned subsequently with a mechanical obstruction due to adhesions which required operation

In two other cases listed as requiring operation and very early in the series the operators agreed to the performance of hydrostatic pressure reduction on the operating table with the open abdomen The first of these was a six month old female with an intussusception of 15

hours duration At operation the intussusception was readily palpated in the sigmoid colon A Foley bag catheter had been placed in the rectum the balloon distended and the catheter connected to a bottle of intravenous saline solution This was allowed to run into the bowel while the operator and first assistant each maintained a finger on opposite sides of the intussusception in the abdomen At the end of five minutes when neither observer had noticed any change in the position or tenseness of the intussusception the attempt was discontinued the hands removed and the bowel examined To our surprise the intussusception had reduced completely and this had all been accomplished so swiftly smoothly and gently that our fingers holding the intussus



A. The intussusception was encountered at the distal transverse colon but the first film taken shows that it has already been reduced to the mid transverse colon

B C and D Show progression of the reduction across the transverse colon

(Continued on next page)

ception had not perceived the change in tension as the intussusception was reduced and the bowel filled with saline solution. The same procedure was employed in an eight months old male with an intussusception of 36 hours duration. This intussusception had reached the descending colon and was similarly reduced very rapidly to the cecum. The final portion of the intussusception could not be reduced until sterile mineral oil had been introduced between the layers of the intussusception and very firm manual pressure made on the cecum just distal to the intussusception. This child also did well.

We feel strongly that barium enema can and should be administered to every child with intussusception regardless of the duration of the disease or the child's condition. Present and previous experience and experimental studies together with the great mass of reported cases

convince us that if manual pressure is avoided and if the barium cannister is no higher than three and a half feet above the operating table gangrenous bowel will not be reduced and perforation of the intestine will not occur. We have seen children in such a degree of collapse that it seemed almost certain that the bowel must be gangrenous who have yet had intussusceptions reduced while blood was being administered and have not required operation. It is scarcely possible to make an absolute diagnosis of gangrene of an intussusception with accuracy without operation. No time is lost by the use of the barium enema since the operating room is being gotten in readiness and the child is having a gastric aspiration and supportive intravenous fluid therapy or transfusion at the same time. Furthermore even if the intussusception should prove to be incompletely reduced by barium



E The splenic flexure has been passed and barium is passing around the intussusceptum in the ascending colon

F The transverse colon and ascending colon and cecum are filled. However there is still a partial filling defect in the cecum and no barium has proceeded into the small bowel. It is obvious that the balloon catheter has been expelled and that there is leakage of barium on the sheets. The operator did not reinsert the catheter into the rectum and attempt another enema but proceeded at once to operation. At operation a small



nubbin of ileum was found in the cecum and through the small McBurney incision was readily reduced with pressure of the thumb. The appendix was removed and the child was discharged from the hospital on the 8th day.

This was an early case. If the catheter is kept in place without leakage such intussusceptions will usually reduce completely without operation. If the catheter is expelled reinsertion in such case with another flow of barium will usually bring success.

enema the more of the intussusception that is reduced by the enema the less remains to be done in the operating room. The problem of reducing an intussusception found at operation to be in the right colon or in the cecum is quite another one from that of reducing an intussusception from the rectum or sigmoid entirely around the colon.

Except for the first few cases most of the incisions in cases requiring operative completion of the reduction have been right lower quadrant McBurney or lateral transverse incisions which expose little more of the peritoneal cavity than the cecum and terminal ileum. The one case of intestinal obstruction due to adhe-

sions occurring subsequent to operative completion of reduction was in one of the earlier cases where a vertical right rectus retracting lower abdominal incision was employed.

Most reports of extensive clinical experience with intussusception mention the occurrence of mechanical intestinal obstruction due to adhesions some time after operative reduction of intussusception. In view of the formal laparotomy required and the extensive handling of the already traumatized bowel this is small wonder and marks a sharp difference from the experience of clinics employing primary hydrostatic pressure reduction.

Pickard reports two such instances of subse-

quent mechanical intestinal obstruction in 43 children previously treated for intussusception by primary operation. Thurston Holowich and McCoy in 109 operations for intussusception report 7 cases of mechanical obstruction due to adhesive bands occurring from two months to three and one half years post operatively. Kahle reports 4 such obstructions, 2 of them fatal, in 88 cases. We reported in 1950 12 cases of mechanical intestinal obstruction (3 of them fatal) developing weeks, months or years after operative reduction in the early series at the Johns Hopkins Hospital.

This is therefore a serious complication and the deaths should fairly be attributable to the treatment of intussusception by the operative method.

Although we are convinced that all children with intussusception deserve a trial at barium enema and expect that between 70 and 75% of them will be cured by the barium enema, we are emphatic that the barium enema should not be stubbornly persisted in. If at any point absolutely no progress is made for ten or fifteen minutes the attempt should be abandoned and operation proceeded with. On the other hand so long as there is any progress, however slow, the attempt should be persisted in.

It is our feeling that the barium enema reduction of an intussusception is as much a surgical procedure as the manipulative reduction of a fracture or the cystoscopic removal of a ureteral stone. The barium enema should be under the control of the surgeon who will make the decision when and if operation is to be performed and who will perform the operation. As close cooperation with pediatricians and radiologists as can be achieved is desirable, but the surgeon should be present at all such manipulations and responsible for their conduct. Any other course is certain to result in delays. The only interpretation which can be placed on some series of hydrostatic pressure reductions which have presented a significant mortality is that a policy of hydrostatic pressure reduction at all costs was in force. The barium enema should be considered as a diagnostic and therapeutic

medium which results in accuracy of diagnosis in essentially all cases and which is curative in 70% to 75% of cases and enormously simplifies the task of the surgeon in the remaining 25% to 30%.

Our own interest in intussusception was aroused in 1933 by the paper of Dr. E. H. Miller of Chicago who described his dissatisfaction with his own poor results (43% mortality in 20 cases) and referred to the remarkable results of Hipsley in Australia with reduction of intussusception by hydrostatic pressure. In reviewing the literature we were struck by the interesting fact that surgeons reporting in 1930 and 1940 mortalities of 20% and 30% for the treatment of intussusception scorned the non-operative methods which had a lower mortality in 1890 and in 1900 and which in 1926 gave a mortality as low as 5% in 100 consecutive cases treated by Hipsley.

A paper of Hipsley's published in 1935 is of particular interest. He reported on this occasion 486 cases of intussusception treated by 16 surgeons with an over all mortality of 11%. Three of the ten surgeons always attempted preliminary reduction by saline enema and had a mortality of 9.8%. The other seven surgeons operated on all patients without an attempt at hydrostatic pressure reduction and had a 14% mortality. This is a significant difference in a large series of patients treated in the period of time and at the same hospital.

Today there is essentially no mortality for intussusception treated in the best pediatric surgical clinics except in the case of children already irretrievably moribund at the time of admission. A comparative study of current mortality statistics is therefore of little value. Such a study published by us ten years ago showed a mortality from intussusception was not so different. It showed a striking difference in the results of clinics employing operative reduction primarily and clinics employing hydrostatic pressure reduction primarily, with the balance heavily in favor of the latter.

Nordentoft and Hansen have compiled the results of a colossal Danish experience with intussusception based on 1,012 cases treated



E The splenic flexure has been passed and barium is passing around the intussusceptum in the ascending colon.

F The transverse colon and ascending colon and cecum are filled. However there is still a partial filling defect in the cecum and no barium has proceeded into the small bowel. It is obvious that the balloon catheter has been expelled and that there is leakage of barium on the sheets. The operator did not reinsert the catheter into the rectum and attempt another enema but proceeded at once to operation. At operation a small

nubbin of ileum was found in the cecum and through the small McBurney incision was readily reduced with pressure of the thumb. The appendix was removed and the child was discharged from the hospital on the 8th day.

This was an early case. If the catheter is kept in place without leakage such intussusceptions will usually reduce completely without operation. If the catheter is expelled reinsertion in such case with another flow of barium will usually bring success.

enema the more of the intussusception that is reduced by the enema the less remains to be done in the operating room. The problem of reducing an intussusception found at operation to be in the right colon or in the cecum is quite another one from that of reducing an intussusception from the rectum or sigmoid entirely around the colon.

Except for the first few cases most of the incisions in cases requiring operative completion of the reduction have been right lower quadrant McBurney or lateral transverse incisions which expose little more of the peritoneal cavity than the cecum and terminal ileum. The one case of intestinal obstruction due to adhe-

sions occurring subsequent to operative completion of reduction was in one of the earlier cases where a vertical right rectus retracting lower abdominal incision was employed.

Most reports of extensive clinical experience with intussusception mention the occurrence of mechanical intestinal obstruction due to adhesions some time after operative reduction of intussusception. In view of the formal hypnosis required and the extensive handling of the already traumatized bowel this is small wonder and marks a sharp difference from the experience of clinics employing primary hydrostatic pressure reduction.

Pickard reports two such instances of subse-

quent mechanical intestinal obstruction in 43 children previously treated for intussusception by primary operation. Thurston Holowach and McCoy in 109 operations for intussusception report 7 cases of mechanical obstruction due to adhesive bands occurring from two months to three and one half years post operatively. Kahle reports 4 such obstructions, 2 of them fatal in 88 cases. We reported in 1950 12 cases of mechanical intestinal obstruction (3 of them fatal) developing weeks, months or years after operative reduction in the early series at the Johns Hopkins Hospital.

This is therefore a serious complication and the deaths should fairly be attributable to the treatment of intussusception by the operative method.

Although we are convinced that all children with intussusception deserve a trial of barium enema and expect that between 70 and 75% of them will be cured by the barium enema, we are emphatic that the barium enema should not be stubbornly persisted in. If at any point absolutely no progress is made for ten or fifteen minutes the attempt should be abandoned and operation proceeded with. On the other hand so long as there is any progress however slow the attempt should be persisted in.

It is our feeling that the barium enema reduction of an intussusception is as much a surgical procedure as the manipulative reduction of a fracture or the cystoscopic removal of a ureteral stone. The barium enema should be under the control of the surgeon who will make the decision when and if operation is to be performed and who will perform the operation. As close cooperation with pediatricians and radiologists as can be achieved is desirable, but the surgeon should be present at all such manipulations and responsible for their conduct. Any other course is certain to result in delays. The only interpretation which can be placed on some series of hydrostatic pressure reductions which have presented a significant mortality is that a policy of hydrostatic pressure reduction at all costs was in force. The barium enema should be considered as a diagnostic and therapeutic

medium which results in accuracy of diagnosis in essentially all cases and which is curative in 70% to 75% of cases and enormously simplifies the task of the surgeon in the remaining 25% to 30%.

Our own interest in intussusception was aroused in 1933 by the paper of Dr. E. H. Miller of Chicago who described his dissatisfaction with his own poor results (45% mortality in 20 cases) and referred to the remarkable results of Hipsley in Australia with reduction of intussusception by hydrostatic pressure. In reviewing the literature we were struck by the interesting fact that surgeons reporting in 1930 and 1940 mortalities of 20% and 30% for the treatment of intussusception scorned the non-operative methods which had a lower mortality in 1890 and in 1900 and which in 1926 gave a mortality as low as 5% in 100 consecutive cases treated by Hipsley.

A paper of Hipsley's published in 1935 is of particular interest. He reported on this occasion 486 cases of intussusception treated by ten surgeons with an overall mortality of 11%. Three of the ten surgeons always attempted a preliminary reduction by saline enema and had a mortality of 9.8%. The other seven surgeons operated on all patients without an attempt at hydrostatic pressure reduction and had a 14% mortality. This is a significant difference in a large series of patients treated in the same period of time and at the same hospital.

Today there is essentially no mortality from intussusception treated in the best pediatric surgical clinics except in the case of children already irretrievably moribund at the time of admission. A comparative study of current mortality statistics is therefore of little value. Such a study published by us ten years ago when mortality from intussusception was not so rare showed a striking difference in the results of clinics employing operative reduction primarily and clinics employing hydrostatic pressure reduction primarily, with the balance heavily in favor of the latter.

Vordentoft and Hansen have compiled the results of a colossal Danish experience with intussusception based on 1042 cases treated by

tween 1928 and 1935 and 796 cases between 1944 and 1949. In the first period Nordentoft collected 419 cases of intussusception; 204 were treated by barium enema alone and of these there were 12 deaths. Two hundred and fifteen had a secondary operation, 16 of which were merely confirmatory and 45 of these children died. There were thus 57 deaths out of 119 cases, a mortality of 13.6% in 1928-1935, a result outstanding for the time. In 450 primary operations there were 116 deaths or a 25.8% mortality. The remainder of the patients were treated by a water enema or by transabdominal manipulation. In Hansen's supplementary report there were 413 cases treated only by barium enema with two deaths and 302 cases secondarily operated upon (in 53 cases the operation was merely confirmatory) with 50 deaths. There were thus 52 deaths in 715 cases, a mortality of 7.3%. The mortality during the same period out of 74 cases operated upon primarily was 18.9%—14 deaths. The remainder of the patients were apparently undiagnosed and died without treatment. Once more the mortality 7.3% was better than most American clinics were reporting in 1949. The cause of the deaths is only very briefly discussed. In the earlier paper Nordentoft states among other things that while the pressure used is generally that of 1 to 1.2 meters, it is never to go above 2 meters, that is to say six feet, which is a great deal more than we think is safe. Nordentoft states— if there is doubt about the reduction—which there will always be if the enema does not pass into the small bowel—an immediate final treatment will be indicated. In early cases a brief delay to await developments will be warranted but should on no account exceed a very few hours. This we consider to be dangerous advice. If there is any doubt about reduction, immediate operation should be undertaken. A reading of Nordentoft's text would suggest that if reduction is not achieved repeated attempts are made during the first and usually only roentgen examination. It would appear from Nordentoft's statements that the patients are the patients of the radiologic service

for this treatment and this may quite naturally lead to over vigorous persistence in enemata manipulation. From Nordentoft's 1935 paper one gathers that in 1194 barium enema reductions, four cases of rupture of the bowel occurred. At all events Nordentoft's and Hansen's results are good for their time, compare favorably with reports from other clinics but are not quite as good as one would have a right to expect.

Helmer reports 130 cases of intussusception reduced with barium enema (over 80%) with no deaths. In 30 additional cases in which laparotomy had to be resorted to in addition there were nine deaths, a mortality of 5.6% for the whole material. In the last three and a half years of the study that is to say from 1911 to 1947 there were nine cases operated upon, one with a resection with no deaths. This is considered to be due to improved anesthesia and post operative care.

Recently Packard and Allen from the Denver Children's Hospital and Kahle from the Charity Hospital in New Orleans have apparently begun to use the barium enema with increasing frequency. On the other hand Dennison of Glasgow after a trial has given it up as unsatisfactory.

Moore apparently attempted barium enema reduction in 17 cases and had only two successes in addition to one which was confirmed at operation. He had one death following resection in his total of 13 cases and 5 deaths without resection. The results seem unsatisfactory with all forms of treatment in this series.

Francis and Friedman report from 1933-1955 38 cases treated by primary operation with four resections and two deaths. In 7 cases barium enema was employed—four with complete reduction and three requiring operative completion. As a result they advise barium enema by the surgeons as the first step in treatment.

Santulli and Fetter from the Babies Hospital in New York recently used primary barium enema reduction in 30 cases with complete reduction in 12 without operation and complete reduction in six more confirmed at operation, that is to say 60% in all. Zachary in Sheffield

after initial resistance has finally tried the barium enema and has been successful in 33 cases out of 54. He points out that his incidence of success has been highest in the intussusceptions under 24 hours and in babies older than six months. Combining these two features he reduced 23 out of 28 or 82% of intussusceptions of less than 24 hours duration in infants older than six months. Hiller in Australia reporting from the Royal Children's Hospital in Melbourne has been employing the barium enema in early cases of intussusception and in 41 such intussusceptions out of a total of 60 succeeded in reducing 24 all of the rest of them having been at least partly reduced. Giordany Bass and Grier of Pittsburgh treated 27 cases of intussusception by barium enema and reduced 22 or 81%. They had one death in spite of complete reduction with viable bowel in a child who had convulsions and died with aspiration pneumonia which may have been due to aspiration of the barium in the fluoroscopic room.

What are the reasons for the resistance among surgeons to a form of treatment which in so many hands has given results superior to those achieved by primary operation? The objections commonly raised are these—

- 1 The original diagnosis may be uncertain
 - 2 It is difficult to be sure of reduction
 - 3 Will not the recurrence rate be higher?
 - 4 Polyps and other tumors cause many intussusceptions and will not be found
 - 5 In the unsuccessful cases a dangerous delay will have been caused
 - 6 The bowel may rupture
 - 7 Non viable bowel may be reduced
- To answer these objections

1 To be sure in most forms of non-operative treatment of acute abdominal conditions as in acute cholecystitis, acute pancreatitis, perforated duodenal ulcer, the first problem is that of diagnosis and the fact that in such conditions this cannot be made with absolute accuracy is an automatic disadvantage. However in intussusception the diagnosis by fluoroscopy is fairly simple, the criteria are characteristic and expertness in their recognition is soon acquired. The

inexperienced may reduce an intussusception without recognizing it certainly but no one can fail to diagnose an intussusception in the large intestine which does not reduce. Intussusceptions still in the ileum cannot usually be demonstrated. However they present as cases of mechanical intestinal obstruction and if enema does not disclose an intussusception the history, the course and the fluoroscopic finding of distended loops will require operation. Furthermore whereas most cases of intussusception are diagnosed clinically a few actually require barium enema for definitive diagnosis. In many clinics in which the barium enema is not used therapeutically a good many intussusceptions have been inadvertently reduced in the course of what was meant to be a purely diagnostic barium enema. Furthermore human nature being what it is pediatricians are much more likely to make a tentative diagnosis of intussusception before they are absolutely certain when this involves merely an enema rather than an operation. As a pedagogic point we perform a barium enema whenever the question of intussusception is raised however confident we may be in a given instance that the suggestion is baseless. The result we believe is substantially earlier definitive treatment.

2 Accuracy of diagnosis of complete reduction is high. We have made an erroneous diagnosis of complete reduction twice in the 77 cases. The second of these was nine years ago. Once we adopted it as iron clad policy that operation would be performed in every case in which there was not free filling of many loops of small bowel we have had no fear of mistaken diagnosis of complete reduction. On the other hand as indicated in a previous section we have in five instances been unsure that reduction was complete only to discover at operation that it was.

Even if we were to insist on operative confirmation of every enema reduction the procedure would still be safer and easier than operative reduction alone. The use of hydrostatic pressure is safer, quicker and less traumatic in the reduction of intussusception than is the manual

squeezing pulling and hauling of operative reduction

3 As to the rate of recurrence we have had only three in the 77 cases This rate of recurrence is about that which is reported from series of primary operative reductions

4 As concerns the possibility of failing to discover such a tumor by barium enema alone the incidence of specific causative lesions in our series has been only 13 in 199 cases of intussusception a total incidence of 6% These occurred practically all in the children over two years of age Furthermore the tumors which cause intussusception are rarely dangerous of themselves Meckel's diverticula occur in perhaps 1% of the population and in addition it would appear from our experience that intussusceptions caused by Meckel's diverticula are not usually completely reducible and will come to operation Polyps in children may be the cause of repeated intussusceptions or may cause anemia from bleeding but are not dangerous if not found at once Large lymphoid patches will usually cause no further trouble and such rare lesions as the occasional small enteric cyst or focus of ectopic pancreatic tissue are of little consequence except as they cause intussusception

5 As for the delay which might be caused by an unsuccessful attempt at reduction by enema it usually requires less than half an hour from start to finish to reduce an intussusception by this means It is our practice to call the operating room as soon as the diagnosis is made and we have usually finished the reduction in time to cancel the operation before preparations in the operating room have been completed This time in any case is employed for lavage of the stomach administration of intravenous fluids and antibiotics and so long as the procedure is under the control of the surgeon from the outset no time will be lost

6 Rupture of the bowel can occur with hydrostatic pressure as well as with manual reduction during operation However it is much less likely to occur with enema since less force is employed and that force is diffusely distributed We employ three feet to three feet six inches

hydrostatic pressure and religiously abstain from manipulation of the bowel There have been a few instances in Scandinavia of rupture from manual reduction through the intact abdominal wall with or without enema

7 As for reducing non viable bowel it would appear that with a pressure of three feet six inches one cannot reduce gangrenous bowel Irreducibility of an intussusception as indicated by our experiments and the previous statements of others is determined by adhesions between the sheaths and by the degree of edema Both factors increase with time and become more effective in preventing reduction as the damage to bowel increases By the time the constriction is so severe as to have produced gangrene the moderate pressure employed will not reduce the bowel and it is important to note that the stress of this pressure is borne by the outer sheath the intussusceptiens which usually remains viable to the end

An advantage of the barium enema reduction so obvious as scarcely to need mention lies in the fact that 70% or more of the children will have escaped an anesthetic and a laprotomy with whatever risks are taken to attend these Furthermore although we insist that even when reduction is obviously complete all children should be hospitalized and placed on antibiotic therapy of the enteric poorly absorbable type to decrease the likelihood of a specific enteritis occurring in the injured bowel these periods of hospitalization are appreciably shorter than in patients who are operated upon The average duration of stay in the hospital for our last 45 patients treated primarily by barium enema was little more than four and a half days with many of the children leaving the hospital in two or three days

It is as well to re-emphasize again the fact that this method is not a substitute for operation nor an escape from operation It is as much a surgical procedure as is reduction of a fracture by traction The surgeon should be as ready to perform a laprotomy if it proves necessary as the orthopedist is to perform an open reduction The treatment should be carried out

by a surgeon and in a hospital. It is not an office procedure nor a kitchen table remedy.

BIBLIOGRAPHY

(a)

- Benson C D and Sharpe H R Jr Recent experiences with intestinal resection in infants and children *Arch Surg* 61 822 833 1950
- Close H G Acute intussusception in children *Guy's Hosp Rep* 81 436 443 1931
- Court S D M and Jones J D T The management of intussusception in childhood *Med Illus* 9 63 68 1955
- Dennis C Resection and primary anastomosis in treatment of gangrenous or non reducible intussusceptions in children *Ann Surg* 126 788 796 1947
- Dennison W M Intussusception in infancy and childhood *Glasgow M J* 29 71 80 1948
- Dennison W M Personal communication 1957
- Fage C H and Howse H G A case of intussusception in an adult without symptoms of strangulation treated successfully by abdominal section *Medico Chir Tr* 59 85 98 1876
- Francis W W and Friedman L J Intussusception in infancy and childhood *Rhode Island M J* 39 560 562 1956
- Gibbs E W and Sutton P W Intussusception *Surgery* 14 708 718 1943
- Gibson R H Dockerty M B and Dixon C F Intussusception in infants and children *S Clin North America* 26 1141 1151 1949
- Goldenberg I S Intussusception *Surgery* 36 732 739 1954
- Gordon E F Intussusception — review of 42 cases from files of New Haven Hospital *Arch Pediat* 57 585 594 1940
- Gross R E and Ware P F Intussusception in childhood experiences from 610 cases *New England J Med* 239 645 652 1948
- Gross R E *The Surgery of Infancy and Childhood* Philadelphia Saunders 1953
- Hogg B M and Donovan E J Acute intussusception in infants and children *Ann Surg* 124 262 267 1946
- Jones J D T Treatment of irreducible intussusception *Brit M J* 2 1304 1306 1953
- Kahle H R Analysis of 151 cases of intussusception from Charity Hospital of Louisiana at New Orleans *Am J Surg* 52 215 224 1941
- Ladd W E and Gross R E Intussusception in infancy and childhood *Arch Surg* 29 365 384 1934
- Ladd W E and Gross R E *Abdominal Surgery of Infancy and Childhood* Philadelphia Saunders 1941
- Lawrence G H and Ulfelder H Intussusception *New England J Med* 247 499 502 1952
- Mayo C W and Woodruff R Acute intussusception *Arch Surg* 43 583 587 1941
- McLaughlin C W Jr Surgical management of irreducible intussusception *Arch Surg* 56 48 57 1948
- Montgomery A H and Mussil J J The treatment of irreducible intussusception in children A study clinical and experimental *Surg Gynec & Obst* 51 415 419 1930
- Moore T C Management of intussusception in infants and children — a report of 43 cases *Ann Surg* 135 184 192 1952
- Packard G B and Allen R P Results in the treatment of intussusception in infants and children *Surgery* 41 567 575 1957
- Parry R H The treatment of irreducible intussusception by lateral anastomosis *Proc Roy Soc Med* 2 Pt 1 271 274 1909
- Peterson E W and Carter R F Acute intussusception in infancy and childhood *Ann Surg* 96 94 97 1932
- Rutherford H Irreducible intussusception in the infant treated by ileo-colic anastomosis *Brit J Child Dis* 6 504 510 1909
- Snyder W H Jr Kraus A R and Chaffin L Intussusception in infants and children Report of 113 consecutive cases *Ann Surg* 130 200 210 1949
- Thatcher D S Intussusception in infants and children *Ann Surg* 140 180 184 1954
- White M and Dennison W M Irreducible intussusception in infants *Brit J Surg* 40 137 110 1952
- Woodhall B Modified double enterostomy (Mikulicz) in radical surgical treatment of intussusception in children *Arch Surg* 36 989 1938
- Zachary R B Acute intussusception in childhood *Arch Dis Childhood* 30 32 36 1955

BIBLIOGRAPHY

(b)

- Clubbe C P B *The Diagnosis and Treatment of Intussusception* 2nd Ed London Hodder & Stoughton 1921
- Giordany B R Bass L W and Grier G W Reduction of ileocecal intussusception by hydrostatic pressure *Radiology* 60 518 526 1953
- Hellmer H Roentgenologic diagnosis and treatment of intussusception in children *Acta radiol* 24 235 258 1943
- Hellmer H Intussusception in children diagnosis and therapy with barium enema *Acta radiol Suppl* LXX 1 120 1948
- Hiller H G Barium enema reduction of intussusception in infancy *M J Australia* 2 157 1955
- Hipsley P I Intussusception and its treatment by hydrostatic pressure Based on an analysis of 100 consecutive cases so treated *M J Australia* 2 201 206 1926
- Hipsley P L Treatment of intussusception *M J Australia* 2 696 697 1934
- Hipsley P L Intussusception *Brit M J* 2 717 721 1935
- Hipsley P L Treatment of intussusception *Surgery* 1 825 837 1937
- Hirschsprung H 107 Falle von darminvagination bei Kindern behandelt im Königin Louisen Kinderhospital in Kopenhagen während der Jahre 1871 1901 *Mitt Grenzgeb Med Chir* 14 555 1903
- Hutchinson Jonathan A successful case of abdominal section for intussusception *Medico Chir Tr London* 57 31 1871
- Kahle H R and Thompson C T Diagnostic and therapeutic considerations of intussusception *Surg Gynec & Obst* 97 693 701 1953
- Koch A and Oerum H P T Intussusception in children Four hundred Danish cases *Edinburgh M J* 9 227 241 1912
- Ladd W F Progress in the diagnosis and treatment of intussusception *Boston M & S J* 168 512 1913
- Lehrmann C Ein Fall von invagination ileocecalis im Röntgenbilde *Fortschr Geb Röntgenstrahlen* XVI 561 1911
- Middlemiss J H Intussusception in childhood radiological appearances on plain radiography *Brit J Radiol* 28 257 263 1955
- Miller E M Acute intussusception *Ann Surg*, 28 706 712 1933
- Monrad S Acute invagination of the intestine in small children *Acta paediat* 6 31 52 1926
- Moore T C Management of intussusception in infants and children—a report of 43 cases *Inn Surg* 155 181 192 1952
- Nelson T Y Place of hydrostatic pressure in the treatment of intussusception *M J Australia* 1 825 827 1949
- Nordentoft J M The value of the barium enema in the diagnosis and treatment of intussusception in children *Acta radiol* 24 481 488 1943
- Nordentoft J M The value of the barium enema in the diagnosis and treatment of intussusception in children illustrated by about 500 Danish cases *Acta radiol Suppl* 51 1943
- Nordentoft J M and Hansen H Treatment of intussusception in children—a brief survey based on 1 838 Danish cases *Surgery* 38 311 319 1955
- Nyborg S Intussusception in children study based on 108 cases *Acta chir scandinav (Suppl* LXXX) 89 1 219 1943
- Olsson I and Pallin C Über das bild der akuten darminvagination bei Röntgenuntersuchung und über desinvagination mit hülfe von kontrastlaven ments *Acta chir scandinav* 61 371 383 1927
- Pickard G B and Allen R P Results in the treatment of intussusception in infants and children *Surgery* 41 567 575 1957
- Pouliquen M et DelaMarnerre Indication du traitement bismuthé dans certaines formes d'invaginations intestinales *Bull et Mem Soc Nat Chirurgie* 53 1016 1021 1927
- Ravitch Mark M and McCune R M Jr Reduction of intussusception by barium enema *Ann Surg* 128 901 917 1948
- Ravitch Mark M and Morgan R H Reduction of intussusception by barium enema *Ann Surg* 133 596 601 1952
- Ravitch Mark M Reduction of intussusception by barium enema *Surg Gynec & Obst* 90 131 135 1951
- Ravitch Mark M The non-operative treatment of intussusception—hydrostatic pressure reduction by barium enema *Surg Clin North America* 36 6 1393 1500 1956
- Ravitch Mark M Intussusception in infancy and childhood *New England J Med* 259 1038 1061 1958

- Retan G M Non operative treatment of intussusception *Am J Dis Child* 33 765 770 1927
- Santulli T V and Ferrer J M Jr Intussusception an appraisal of present treatment *Ann Surg* 143 8 17 1956
- Sjostrom P M Über unblutige desinvagination von darminvaginationsfällen mit hilfe von kontrast einlauf unter roentgendurchleuchtung *Der Chirurg* 6 706 714 1934
- Stephens V R Ileocecal intussusception in infants with special reference to fluoroscopic findings *Surg Gynec & Obst* 45 698 700 Nov 1927
- Stephens V R Acute intussusception—manipulative reduction under fluoroscopic control *Am J Dis Child* 35 61 64 1928
- Zachary R B Acute intussusception in childhood *Arch Dis Childhood* 30 32 36 1955

AUTHOR INDEX

- Allen R P 13 61 62 110 114
 Atkinson F R 16
 Aurelianus Caelius 3
 Barbette P 3 6
 Bas L W 115
 Benson C D 61 62
 Bolling R W 16
 Chaffin L 13 14 22 63
 Child C G 26
 Close H G 16
 Clubbe C P B ix x 10 68
 Collinson F W 10
 Court S D M 14 18 59
 Cushing H 18 50 56
 Dennis C 61 62
 Dennison W M 14 15 17 59 61 114
 Dick B M 17
 Donovan E J 16 65
 Dowd C N 10
 Ellison W B 41
 Ellman R 17
 Fagge C H 54
 Ferrer J M 14 114
 Fiedler F A 6
 Fitzwilliams B C 16
 Forest W E 51
 Forshall E 25 26
 Fox P F 14 18 61 65
 Francis W W 114
 Fuchsius C 6
 Fulton J F 41
 Gerson C 6
 Gibbs E W 65
 Gibson R H 65
 Gilmer R 41
 Gordany B R 115
 Goldman L 17
 Guet G W 115
 Grollman A 40
 Gross R E 13 19 20 22 26 57 59 65
 Hachmann L N 6
 Haenisch F 9 10
 Haller A 6
 Hansen H 113 114
 Helmer H 14 114
 Hiller H G 115
 Hippocrates 3 66
 Hipsley P I ix 10 14 19 16 63 78
 113
 Hirschsprung H ix x 3 7 10 16 17
 67
 Hogan B M 16 63
 Holowach J 14 18 20 26 113
 Holt I E 5
 Houck C R 41 49
 Howse H G 54
 Hunter J x 3
 Hutchinson J x 5 7 30 66
 Illingsworth C F 17
 J ghers H 30
 Jones J D T 18 57 59 61 63
 Kahle H R 13 14 18 19 0 22 113
 114
 Koch A 68
 Kraus A R 13 14 22 63
 Ladd W E 8 10 54 68
 Lawrence G H 63
 Lehmann C 9 10 68
 Leichtenstern O 3 4 7
 Lewis D D ix 61
 Linday F C 14 15 16
 Ling J T 13
 MacFarlane D A 18
 MacMahon B 14 15 16
 Maunsell S E 55 61
 McCoy L E 14 18 20 113
 McCune R M 3 45
 Mckusick V A 30
 McLaughlin C W Jr 65
 Miller E H ix 113
 Mitchell S 4
 Monrad S 63
 Montgomery A H 59 61
 Moore A W 41
 Moore T 114
 Mortimer J D 57
 Murhead E E 42
 Mussil J J 59
 Nordentoft J M 14 19 20 22 52 80
 113 114
 Nothnagel H x 41
 Nuck A 6
 Oerum H P T 63
 Ohle G H 6
 Olsson G 10 63
 O Sullivan W D 6
 Packard G B 13 61 6 11 114
 Pallin G 10 68
 Parry R H 29 61
 Perrin W S 14 19 16
 Peyer J C 3
 Pirogoff N J 7
 Pouliquen M 10 63
 Power D A x 41 49
 Praxagoras 3 66
 Rachelson M H 15 18 19
 Retan G M 10 68
 Rokitsky K x
 Rutherford H 29 61
 Santulli T V 14 18 114
 Selye H 4
 Senn N ix x 5 41
 Sharp H R 61 62
 Smith J L 5
 Snyder W H Jr 13 14 22 65
 Soranus 3
 Spence J 14
 Stephens A R 10 68
 Sutton P W 65
 Tav W 7
 Thatcher D S 13 20 22 61 63
 Thomas L 1 18
 Thomson W W 6
 Thurston D L 14 18 20 22 26 113
 Treves F 18
 Friedman L J 114
 Lifelder H 63
 Vanatta J 42
 Wakely C I G 16
 Ware I F 19 20 22 26 65
 Watts J W 41
 Wells S 7
 White M 9 61
 Wilson J R 6
 Wilson O H G
 Woodhall B G C 63
 Zachary R B 61 C 114
 Zeta 13

